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The Public Health Nurse

Volume XIX March, 1927 Number 3

Does Prohibition Work

By Martha Bensley Bruère

Measuring Rods in a Visiting Nurse Service

By Marguerite A. Wales and Mabel C. DeBonneval

Our Czecho-Slovak Friends

By Katherine L. Lawless

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The PUBLIC HEALTH NURSE

Official Organ of The National Organization for Public Health Nursing

Volume XIX MARCH, 1927 Number 3

MILESTONES

Since the early beginnings of public health nursing, nurses have met together for the inspiration and help to be gained from the discussion of common problems. In various localized areas board members have similarly recognized the value of this kind of interchange of experiences and ideas. Now, born out of the enlivened interest of the lay representation at the Atlantic City convention, has come a broader recognition of the responsibility for leadership that rests upon the Board of Directors of a local nursing association. The Institute for Board Members to be held in New Haven in April, representing associations from Maine to Virginia and Massachusetts to Indiana, is indicative of the desire of local directors to accept the trusteeship with which they are charged and to intelligently participate in the administration of the nursing service for their community. This institute marks another and very prominent milestone in the history of the progress of public health nursing.

INDEXING NURSING LITERATURE

In a statement entitled "A Plan for the Publication of an Index to Periodical Nursing Literature," by Isabel M. Stewart, which appears this month in *The American Journal of Nursing*, Miss Stewart says:

> There seems to be no question about the need of such an Index to Nursing Literature. The only question is how we can bring it into being and how it can be financed. The present plan is to begin in a very simple way with a monthly publication, which would have an extra cumulated list of references at the end of the year, and if possible, at the end of each quarter as well. An expert librarian would be put in charge of the work, and the Index would probably be issued from the office of the National Health Council Library, 370 Seventh Avenue, New York.

These general conclusions were arrived at following several meetings of a group of people who have insistently felt the need of something more comprehensive than now exists for reference on nursing literature. The nurses in this group were Miss Isabel Stewart, Miss M. A. Nutting, Miss Carrie M. Hall, Miss Helena Stewart, Major Julia Stimson, Miss Mary Roberts and Miss Ada M. Carr. Miss Mary Casamajor of the National Health Council Library, Miss Marjorie Wildes of the Yale Medical Library, Miss Florence Bradley of the Metropolitan Life Insurance Library, and Miss Donelda Hamlin of the Hospital Library and Service Bureau of Chicago, represented the library group.

Generous offers of assistance were received by the committee from the Surgeon General's library in Washington and from other sources but the project to be of real value must necessarily be intensive and cannot be self-supporting unless a substantial list of subscribers can be assured. The plan for the Index has been endorsed by the three National Nursing Organizations and the original voluntary committee has been taken over officially by the National League of Nursing Education with Miss Isabel Stewart as chairman. The committee hopes for the coöperation of all interested in nursing education in this experiment which will take us another step forward towards an established professional status and will provide us with the authoritative and easily accessible information on sources of literature concerned with nursing now impossible to obtain. The grow-

ing literature on public health nursing alone and the rapidly changing phases which it records, make some such plan as has been suggested imperative if we are to preserve our records, not only for reference but for history.

Is there a nursing shortage? That the Committee on the Grading of Nursing Schools is getting into its stride, and a good sweeping sort of stride at that, is evidenced by the announcement on page 136. Public health nurses are very vitally interested in every phase of the plan for the Five Year Program submitted by Dr. May Ayres Burgess and recently adopted by the Committee. There can be no doubt that public health nurses, individually and as a body, will heartily give every assistance in their power towards the acquisition of the facts now needed. The Five Year Program is now in printed form and can be obtained from the Committee.

INSTITUTE FOR BOARD MEMBERS OF PUBLIC HEALTH NURSING ORGANIZATIONS

A three day Institute for Board Members of Public Health Nursing Organizations will be held in New Haven, April 4–7, under the auspices of the New Haven Visiting Nurse Association, in affiliation with the National Organization for Public Health Nursing.

It is specially designed for board members from the North Eastern States, Massachusetts to Virginia, and Maine to Indiana, but registrants will be welcomed from any part of the United States or Canada.

The Institute is really one in Trusteeship covering the duties and responsibilities of Board Members—from the problems of raising money to those of ensuring a maximum return for each dollar expended, and the subjects to be discussed will be limited to questions which are the concern of the board members, as distinct from those of the Nurse Director.

It is hoped to make clear just what the function of a board member is, and how she can keep abreast of current public health practice, so that without interfering with technical professional problems she may free the nurse from unnecessary burdens.

The speakers on each subject will represent the viewpoint of the Public, of the Board Member, and of the Public Health Nurse. After each general meeting there will be round table discussion of the special problems peculiar to associations of various sizes.

This Institute will be confined to board members only, except for those nurses who are especially invited to lend their counsel in matters of professional concern.

Membership cards (which are transferable) will cost ten dollars and may be obtained at the registration desk, or by previous application by mail. All correspondence should be addressed to:

Board Members Institute, 35 Elm Street, New Haven, Connecticut.

PROGRAM

April 4th

10–12 A.M. Registration at Visiting Nurse Association.

2 P.M. **The Organization of the Board and its Relation to the Professional Staff.**
The Board and its Committees, Miss Lillian E. Prudden, President, New Haven Visiting Nurse Association.
Relation between the Board and the Professional Staff, Katharine Tucker, R.N., General Director, Philadelphia Visiting Nurse Society.

3:30 P.M. **Round Table.**
Discussion of foregoing problems, rural and urban, in four sections—organizations of: 1 nurse, 2 to 5 nurses, 6 to 15 nurses, and 16 nurses and upward.

8 P.M. **What is the Function of Board Members? From the Viewpoint of:**
A Board Member, Miss Josephine Goldmark, New York;
A Public Health Nurse, Mary S. Gardner, R.N., Director, District Nurse Association, Providence;
The Community, C.-E. A. Winslow, Dr.P.H., Yale University, New Haven.

April 5th

8 A.M. **Nurses' Round Tables.**
Visiting Nurse Association.

9:30 A.M. **Public Health Nursing in its Relation to the Medical Profession. From the Viewpoint of:**
The Physician, Haven Emerson, M.D., Professor of Public Health, Columbia University, New York;
The Nurse, Janet Geister, R.N., Executive Secretary, American Nurses' Association, New York;
The Board Member.

2 P.M. **Mobilizing Public Support for Public Health Nursing.**
The Psychology of Public Health Education, Dr. W. W. Peter, Shanghai, China.
The Technique of Annual Reports, Ira V. Hiscock, Assistant Professor, Department of Public Health, Yale School of Medicine.
Educational Publicity to Raise Money and to Increase Public Demand for the Service, Hazel Corbin, R.N., Director, Maternity Center Association, New York.

3:30 P.M. **Round Tables.**

5 P.M. Tea at Nathan Smith Hall, Yale School of Nursing.
New Trends in Nursing Education, Annie W. Goodrich, R. N., Dean, Yale School of Nursing.

April 6th

8 A.M. **Nurses' Round Tables.**
Visiting Nurse Association.

9:30 A.M. **Financial Problems.**
The Financing of Public Health Nursing.
Local Responsibility for the Support of National Health Organizations, Mrs. Anne L. Hansen, R.N., President, National Organization for Public Health Nursing.
Salaries, Vacation, Sick Leave, Sabbatical Leave, and Attendance at Conventions as Factors in Efficiency.

11 A.M. **Round Tables.**

4 P.M. **Public Health Nursing in its Relationship to Social Agencies.**

7 P.M. Dinner, New Haven Lawn Club.
Address by George E. Vincent, Ph.D., President, Rockefeller Foundation.

April 7th

8 A.M. **Education.**
Self-Education of the Board Members.
What the National Organization for Public Health Nursing Can Offer to Board Members, Elizabeth G. Fox, R.N., American Red Cross, Washington.
The Responsibilities of Leadership.

Names of speakers not yet assigned to subjects will be announced later.

PROBLEMS IN CHILDHOOD TUBERCULOSIS

By J. A. Myers, Ph.D., M.D.

Medical Director, Lymanhurst School for Tuberculous Children, and
Associate Professor of Preventive Medicine, University of Minnesota

TUBERCULOSIS is a disease that is not commonly found in the unborn child. That is, the expectant mother usually does not transmit the disease to her offspring unless the disease has attacked the placenta, and this is not common in the human family. However, there is some evidence to show that acute febrile diseases may break down the barrier effect of the placenta and allow tubercle bacilli in the blood stream of the mother to pass through the placenta into the blood stream of the child. Therefore, our first problem in childhood tuberculosis is to prevent the bacilli from the tuberculous disease in the expectant mother from reaching the body of her unborn child. Prenatal workers can do much to help solve this problem.

Inasmuch as tuberculosis is not common in the unborn child, it is obvious that a greater problem is in preventing the child from becoming exposed to tuberculosis after birth. In fact one of the most dangerous periods of human life from birth to death in senility is during the period of infancy. This is because of the fact that tuberculosis affects the human body differently at different age periods of life. During the period of infancy the mortality rate from tuberculosis is quite high. In fact several observers have reported rates as high as 50 to 75 per cent during the first year and 25 and 50 per cent during the second year.

Causes of Tuberculosis Mortality in Infancy

Why is the mortality rate so high during the period of infancy? One reason is that the infant, when exposed to tuberculosis, is often exposed extensively and frequently. It has only a few associates but these are close, such as the father, the mother and near relatives. If one of them happens to be suffering from tuberculosis it is obvious that the infant may come in contact with tubercle bacilli in large numbers daily or even several times daily. Infants so exposed are very likely not only to become infected but also to develop tuberculous disease.

A father noticed during the latter part of one summer that he was somewhat below par. He was carefully examined and the sputum was found to be positive. For some reason, however, his physician failed to inform him of the fact. There were two small children in the family, a girl of three years and a boy of a few months. During the winter the father, not knowing that he had the germs of tuberculosis in his sputum, fondled the children a great deal. One day the baby boy showed manifestations of severe illness. A physician was called and found him to be suffering from tuberculous meningitis, the disease resulting fatally in a short time. Obviously, this child had had an extensive exposure over a considerable period of time.

Another reason why the infant has such a poor chance when tuberculosis develops is that his protective mechanism has not yet become well developed—I refer to the lymph nodes which in later life act as splendid filters, in other words, serving as outposts or coast guards. It happens that in the infant these lymph nodes are of a very loose and open structure, so much so in fact that they do not at this age period serve as good filters. When the germs of tuberculosis gain entrance to the body of the infant, therefore, many pass through the outposts and finally reach the blood stream which distributes them to all parts of the body. This is particularly apt to happen if the germs are introduced in large numbers. Many then gain entrance to the tissues of the vital organs where they multiply, disseminate their poisons, and destroy the tissues with the result that the patient is found to

be suffering from extensive tuberculosis.

Still another reason is that the infant has not in many cases had an opportunity to develop an immunity to tuberculosis from previous slight infections. Therefore when large numbers of the germs reach his body he may resist them very little or not at all.

Tuberculosis in Young Children

Between the ages of two or three years and puberty we encounter another problem. It is a problem because the scene changes so extensively that frequently the disease is entirely unrecognized. In other words, the protective mechanisms, particularly the lymph nodes, have become excellent filters so that when the germs of tuberculosis enter the body they are usually filtered out. They are entrapped in the lymph nodes and here they may multiply and actually set up disease, in some cases even to the extent of completely destroying the nodes and, if such nodes are located near the surface of the body, they may rupture through to the surface and discharge pus over long periods of time. If it is the lymph nodes inside the chest or abdomen which become so diseased they enlarge but the pus of course will not be discharged on the surface of the body.

A more usual condition, however, is one in which the disease in the lymph nodes does not become so extensive and this is the condition which so frequently is unrecognized although it may cause certain symptoms. This type of disease constitutes a great problem because it so often is not detected. If it is detected and properly treated children suffering from it may so recover as never to show any further manifestations of it. In fact many cases heal spontaneously.

Unfortunately a small percentage of children between the age of two or three years and the period of puberty develop a much more extensive form of disease. That is the type that so frequently proves fatal. What percentage of these cases develops from the breaking down of tuberculous lymph nodes within the abdomen or chest no one knows. But it is reasonable to believe that not a few of them have their origin from this source and that some may be saved provided their lymph node tuberculosis is detected early and they are given the proper treatment over a sufficient period of time. I do not want to leave the impression that all cases of tuberculosis during this period of life are easily managed. Once the disease becomes disseminated the condition is serious. For example:

A little boy of nine years was brought by his father for an examination because he had been losing weight, seemed flushed and had a poor appetite. He was found to have an extensive tuberculous disease in both lungs. Although immediately placed in an institution that provided all facilities for the modern treatment of tuberculosis, his disease progressed rapidly and death occurred only a few months after he was first examined.

Another example is of a girl of six years who was brought to a clinic because of considerable loss of weight and a severe cough. It was found that her father at home was suffering from tuberculosis and that other members of the family had died from this disease rather recently. She was considerably emaciated, pale, and had all the appearances of an advanced consumptive. Examination of her chest revealed unmistakable tuberculosis throughout both lungs. At the present time the disease is widely disseminated, and it appears that she can live only a few weeks or at most a few months.

Such cases, however, are unusual in this period of life, the rule being, as I have stated, for the disease to attack the lymph nodes and to be held in check there.

Tuberculosis After Adolescence

During the period of puberty and the ages beyond, tuberculosis very frequently attacks the lungs, particularly in their upper portions and is spoken of as the adult type of tuberculosis. At this time we encounter another problem in childhood tuberculosis. It is a problem first of prevention. In other words, our efforts should be to find the cases of lymph node tuberculosis and so treat them that when the period of puberty and later years arrive the affected individuals will have sufficient resistance and will know enough about good health and its

preservation to prevent the development of the adult type of tuberculosis.

Another problem during this period is to treat the child who is already suffering from the adult type of disease, and here again, the treatment is easier if the disease is detected before it becomes extensive. A great deal is said about detecting all tuberculosis while it is in an early stage. Those who see and treat tuberculosis know that this will never be possible because many cases are extensive when the first symptoms appear. In other words the disease may begin as a massive process. In some cases it may be so mild over a considerable period of time as to cause slight or no symptoms. The patient feels quite well. Then suddenly and without warning the disease extends, symptoms appear and a massive process is found to be present. Therefore, we can never hope in this period or in that of adult life to detect all cases while the disease is small in amount. For example:

A girl of sixteen years developed a slight cough and lost a little weight. When she was brought for examination she had advanced tuberculosis. In such a case obviously little or nothing can be done so far as treatment is concerned more than to make the patient as comfortable as possible.

The relation of childhood tuberculosis to the adult type of disease has been a subject of much discussion. At an earlier time it was believed that practically all tuberculosis in adults was due to the reactivation of tuberculous processes developed in childhood. In fact, Von Behring said, "Tuberculosis of the adult is the end of a song begun at the cradle." Recent experimental work and careful observation of tuberculous cases have proved that by no means all cases of tuberculosis in adults do develop from childhood infections. In other words, the adult is capable of developing disease from exposure to others. He may have had tuberculous infection in childhood or he may never before have had a tuberculous infection. If he did have a tuberculous infection in childhood and it has become well walled off, perhaps his resistance is greater for it. Nevertheless coming in contact with massive doses of tubercle bacilli frequently may suffice to cause him to develop tuberculous disease. We must therefore get away from the idea that one adult cannot contract tuberculosis from another, or that the adult always develops disease from his old childhood infection.

Prevention the Great Problem in All Ages

The great problem then in childhood tuberculosis is that of protecting the children. We must do all that is possible toward the following measures:

First—That children are born in a good state of nutrition and in good health and that the germs of tuberculosis do not enter their bodies before birth. Pasteur said, "In order to save a race that is infected by an infectious disease, the best plan is to save the cocoon."

Second—That children be protected from exposure. This is particularly true during the first two years of life when every attempt must be made to isolate infants from tuberculous patients and all other sources of exposure, whether of the human, bovine or avian types of tuberculosis.

Finally—That exposure is important during the period of puberty and on through adult life. Therefore exposure should be prevented just as far as possible in all ages of life.

Tuberculous Infection and Tuberculous Disease

There is a great difference between tuberculous infection and tuberculous disease. This difference is not always clear to the public. Very frequently after examining a patient and finding tuberculous disease that does not cause him to feel ill, considerable difficulty is encountered in convincing him that he should have treatment. One of his arguments is that 75 to 80 per cent of the people in this country have a "touch" of tuberculosis. He says that if this is true, why should not all of these people take the treatment that is being recommended in his case?

This is a real problem for it may be difficult to convince him that there is a tremendous difference between tuberculous infection and tuberculous disease. The percentage that he is talking of is a percentage of persons that have

been infected, but only a few of whom have developed tuberculous disease. Therefore, in our good health teaching, we should make clear to all with whom we come in contact the following difference:

The person with only tuberculous infection has come in contact with the germs of tuberculosis with the result that they have gained entrance to his body but have been so brought under control that they have never caused disease.

The person who has developed tuberculous disease is the person who has come in contact with the germs of tuberculosis with the result that they have gained entrance to his body, but have not encountered there enough resistance to hold them in check and wall them off. In other words, they multiply, produce their poisons which in turn cause the death of the tissues adjacent to them, enter the blood stream and cause symptoms such as temperature, accelerated pulse, etc.

Tests for Tuberculosis

Now, the detection of tuberculous infection is made easy by the von Pirquet or Manteaux tuberculin tests. If a child or an adult has tuberculous infection a reaction will develop about the site of the area being tested, unless he is also suffering from one of the acute communicable diseases such as measles and scarlet fever or unless he has advanced tuberculosis and is near death.

It was formerly believed that once a person became infected the tuberculin test would always reveal evidence of that infection even if the person lived to an old age. We have recently come to know that in at least a few cases this is not true. A child, for example, may even have tuberculous disease giving a markedly positive tuberculin reaction, but when the disease heals, subsequent tests show that the reaction begins to fade and in time dies out completely. Therefore such cases will not be detected in later years by the tuberculin test unless they become reinfected.

The detection of tuberculous disease in childhood constitutes a great problem. If the disease has attacked the lungs or other easily examined parts of the body it is detected in precisely the same manner as tuberculosis in adults. But, as I have already said, during the period of childhood the disease usually does not attack the lungs but rather the lymph nodes. Those nodes most often attacked are the ones located remotely from the surface of the body and in the past they have been extremely difficult to examine. I refer to those at the roots of the lungs known as the tracheo-bronchial lymph nodes. Disease in them heretofore has been allowed to pass undetected.

In the first place, tuberculosis of these nodes causes a group of symptoms which differs considerably from tuberculosis of the lungs and this fact in the past has been sufficient to cause many physicians to overlook the disease.

Again a child in whom tuberculosis is suspected may be taken to a physician who makes very careful and complete examination of the lungs as he would for an adult, but upon finding no evidence of disease in the lung substance, states that tuberculosis does not exist, when in reality there is plenty of disease in the lymph nodes at the roots of the lung.

With recent contributions to our knowledge of tuberculosis as well as recent diagnostic aids such as the carefully made stereoscopic x-ray plates, this problem should be easily solved; that is, physicians everywhere will not be satisfied with the examination of the lungs of children, but will insist upon careful examination of the lymph nodes at the roots of the lungs. When this is done, and the disease is detected there and the child is placed under the proper treatment, there is every reason to believe that more cases will be successfully treated and that the adult type of tuberculosis will be definitely diminished.

OUR CZECHO-SLOVAK FRIENDS

By Katherine L. Lawless

Director, Pittsburgh International Institute

I WISH I could take you to Czecho-Slovakia to visit a native village, to talk with the men, women and children, and to see the preparations they make for their festivals. I wish you could see the springtime and autumn in their villages before you visit these same people after they have traveled many miles across land and sea to the great new country, America.

The Loaf of Bread. Note the Gaily Decorated Home in the Background

When the harvest was first over and there was no more work in the fields, you could wander up any village street and find the women gathered in groups, sewing on their beautiful embroidered sheets, pillows or dresses, for until the cold drove them indoors it was on the doorstep they would work. And now that it must be indoors, when all the duties of the house are finished they still gather together when they sew to talk about the happenings of the village. The lines on their faces and the hands, worn hard with toil, give one the impression of sadness, but that is lightened by the bright colors of their gowns.

In the tiny houses one finds, especially in the kitchens with the unique tile stoves, such gay colors on the walls and such pottery on the plate rails above the stoves as have been the enjoyment of many travelers. With great pride the people will show you their many costumes saved for Sundays. The young girls always have trousseaux and hope chests ready; the linens are piled up over the bed, embroidered by their own hands during the cold winter days. The furniture has its touches of cheery color, and although it must be admitted that one could never be very much *at ease* on the chairs or benches, they are charming enough almost to make one forget that. It is from such homes as these that many of our new Americans have come.

If we had traveled in the springtime, we should have seen the men and women working together in the fields; the women barefooted, toiling away from early morning until early evening with their babies tied up in shawls on their backs or fixed in little home-made hammock effects. And on Sunday, their holiday, we should have seen them, men and women, in all their gayly embroidered dresses and suits going off to church laughing and joking. Once in the church, however, they make a picture that will not soon be forgotten by those who have seen it. Their sincerity and piety in giving themselves to the service is most impressive. Together with the holiday time with all its gayety and fun and the dances on the green with all their colorfulness, it forms a picture which holds the memory forever.

I recall one scene which if I were an artist I should long to paint. It was a little village in Slovakia where a group of young men and women had gathered for a good time. One of the

amusements was a merry-go-round of swings which was manipulated by a number of boys hidden by canvas. Around and around they went, alternately reversing. As they swung about, the bright shades of red and blue in the girls' costumes and the elaborate, picturesquely embroidered coats of the boys gave one a glimpse of the inner soul of those villagers. The crude little hand-organ began to play, and to them any music at all was enough to call for singing. Their voices pealed out, as around they swung, and the picture itself was beautiful but it brought a great deal more into one's thoughts. All week, no doubt, those young folks had toiled and labored in the fields—but to-day was the great festival day; they could drop all their worries and burdens and be as free as children. The simple amusement of a home-fashioned merry-go-round was a delight for them.

It is these same people who, having heard of the great wonder of the new world where wait wealth and happiness, have decided to leave their friends and home-ties and travel the many miles over the sea to visit this land of opportunity and dreams. They have heard stories almost too marvelous but have faith sufficient to believe that not too much will go wrong. They have only to reach America and sorrows and misfortunes will be remedied.

We must think of the Czecho-Slovaks as composed of four more or less distinct groups of people—the Czechs or Bohemians, the Moravians, the Slovaks, and the Carpatho-Russians or Rusinians. The Czechs have a larger admixture of Teutonic blood than their Slovak brethren. For centuries they have had the advantages of an advanced culture. They have been known as lovers of liberty and of learning. Naturally they were in position to take the lead when the new republic of Czech-Slovakia was born.

The Moravians are very closely akin to the Czechs, but whereas the Czechs are irrepressible free-thinkers, the Moravians are noted for their simple piety and their adherence to the faith of their fathers.

The Slovaks have been for the most part simple agricultural people. Under a land system not far removed from feudalism they have made slow progress in the direction of modern industrial development and in the general spread of the advantages of education. Up until recent times the clergy were practically the only educated persons in the villages.

The Rusins from the mountains at the extreme east have been even farther retarded than their Slovak compatriots. A little group of early Russian settlers, retaining their old Slavonic tongue and the rites of their eastern religion, they have been isolated in their mountain homes far removed from the streams of modern progress and clinging tenaciously to their eastern or "Russian" traditions.

In an American Environment

Immigrants, in small numbers at least, have been coming to the United States from these groups from the earliest times. Bohemians came as early as 1625. The heavy toil of their agricultural life had peculiarly fitted them for the work of the steel mills and the coal mines to which they fell heir. They were much sought after by American industrialists in the latter nineteenth and early twentieth centuries. It was natural that Pittsburgh should draw thousands of Slovaks and Rusins to man its mines and mills. Many a district in Pittsburgh's alternating river flats and steep hillsides can be described as a Slovak settlement.

Let us visit a settlement of these transplanted European people. We must climb several flights of steps to reach the crest of the hill with its rows of smoke-dimmed frame houses. Down in the valley more of the buildings are a dull red brick. It is December and a light fall of snow brings out the black walls and fences in relief. The dull overcast sky accentuates the drabness. These people have sought the hilltops for the fresh air. Had

we visited in the springtime, we should have seen the women and the men planting their tiny garden plots, which they have carefully enclosed by fences, terraced and made secure by retaining walls, to prevent a sudden descent to the valley below.

We enter a house and find two families occupying the building, each with two or three rooms. The usual family is large and there must also be counted several boarders who work on

A Row of Smokestacks in a Steel City and Czecho-Slovak Homes

night-shift. These men are sleeping in the front room as we interview the mother in the kitchen which is the home. The walls are dark green; the white or blue tile stove of European days has been superseded by a black one, which must give service until the family will be able to make the first payment upon a much coveted modern white range. There is a roaring fire, which seems to be crackling and glowing extra well to make the room a wee bit cheerier. There is a table with its oilcloth cover which only on special occasions will become a red cloth. A half dozen straight chairs and a sewing machine of which instrument only a few of the mothers may count themselves the very proud possessors, make up the rest of the furnishings. To brighten the dark wall a runner saved from European days has been hung. It has a bit of verse in the native language worked in red and an appropriate picture pattern embroidered in the center. Bright calendars collected from neighborhood grocers and butchers occupy prominent places. Hung by the sink is a cardboard brush and comb receiver also bearing witness to the enterprise of a local tradesman. The mother is sewing on the machine for this is the way she makes the children's clothes now. She uses some dark serviceable material in place of the homespun which she would have embroidered in gay colors at home. She uses a simple straight pattern instead of the full plaited skirts of old.

The older children are in school, and only the tiny ones are left with her. The husband is at work in the mill. All through the day the mother cooks and sews and there seems to be little time for any play for her. She sees the children as they inevitably change. They are growing away from the old mother tongue. Lost in her many household duties she senses, wonderingly, the gap that is growing between them and her. Proud she is that they are Americans but it is hard to understand the great change. They have crossed the bridge from the old to the new so quickly, and she is lonesome for the old companionships. She goes to church of course but she hurries back to look after her family. Any playtime that she has now is different from her play in the old days.

We wonder, are these the same people we saw across the water, the same village folk we were so eager to visit? Yes, they have come to our shores to be of us, to be Americans. Let us not keep them isolated, let us know these mothers as we travel in and out of their homes, let us help them understand their new country.

DOES PROHIBITION WORK?

By Martha Bensley Bruère

Director of Study, National Federation of Settlements

Editor's Note: We hope to have comments and opinions on the points Mrs. Bruère makes on this pertinent subject.

IT WAS to answer this question that in mid-summer, 1926, the National Federation of Settlements began a study of the operation of the Eighteenth Amendment as it affected the neighborhoods with which social workers were in contact.

Dr. Haven Emerson precipitated the thing by asking very pointedly in the *Survey* of May 15th whether the social workers of the country had ceased to take an interest in this great piece of social legislation. They accepted the challenge, appointed a committee of which Miss Lillian D. Wald was chairman, made a survey covering towns and cities in most of the states of the Union, and will shortly publish the results, *Does Prohibition Work?* Harper & Brothers, $1.50.

This study began with a questionnaire. We social workers have grown to place great dependence in questionnaires and I, personally, am beginning to think them broken reeds. But, anyway, that is the way we started this study. The questionnaire had 52 questions, an appalling thing in itself, and it was an effort to balance the following periods against each other:

The pre-prohibition time.
The short time immediately after the passage of the amendment when enforcement was reasonably complete.
The present time when there is said to be a widespread disregard of the law.

This, in our minds, was going to make a very complete picture. Well, that is not what we have got, and here are the reasons why:

First, there were some 33 states in the country which had passed prohibition laws of their own before the federal amendment went through Congress. The time immediately before the passage of the amendment was not much different from the time immediately after so far as they were concerned. Because of that the first division in the study broke down absolutely.

And second, the next division broke down in many places also for we found two different results and in one, where the law had practically not been enforced at all, the brief dry period did not apply. In the other, where it had been enforced, there was no change between that time and the present.

What the questionnaire did very definitely was to bring out the fact that along with the amendment had gone a practically universal prosperity. This fact is testified to by the social workers from the Atlantic to the Pacific and from the Gulf to the Canadian border. Plenty of people reported that this was dependent not on prohibition but on high wages and steady employment. On the contrary, others reported that the saving of the money people had formerly spent on drink was the most important factor in it. Another practically universal report was that the school attendance had largely increased. More children were going to school and fewer into industry since the amendment was passed. This, again, may be related to the general prosperity, but nevertheless the fact stands.

The thing we have not got in this survey and which the public health nurses more, perhaps, than any other group in the community could help us to, is conclusive information as to the effect on community health. We have a few statements from physicians and one or two from nurses, but that great body of opinion which must be in the experiences of the nursing profession does not appear in this report.

In addition to the questionnaire, the inquiry was pursued by personal visits. Our group went up into New England as far as Fall River on the coast and Hanover in New Hampshire; it went south beyond Philadelphia, west to the Pacific and south to the Gulf. None of these visits were made in order primarily to gather information, for the material that this report is made of could not be secured by an investigator from outside. It is, so far as we can make it, a record of the experiences of people who have been years in the same neighborhood and have seen the changes. These visits, as well as the questionnaire, were for the sole purpose of getting them to set down their experiences and send them in for this study. We have received 193 reports and, in addition to this, hundreds of personal statements on phases of the situation.

Conclusions

Ever since the beginning of the study, people have been saying to us, "Well, what are your conclusions?" If the whole United States were boiled down to something the size of one county, and that an eastern county rather than a western one, it might be possible to answer this question. What we have found out is that prohibition, take it by and large, is no longer a moral question but an economic one and that the controlling factor in whether it does or doesn't work in a given locality is not law, but tradition, industry and education.

For example, the Latin races, which make up one of our largest foreign born groups, have always been accustomed to the use of wine. They have always made it for themselves and as a race they have not drunk to excess. As a race, too, they are not observing the law because they are continuing to make their own wine and to drink it and sell it.

As a contrast to them are the American born people of the Northwest coast. They are largely Nordics and have been four or five generations away from European influences. The old drink traditions of their remote forefathers have been overlaid by the American custom of prohibition. With them the amendment works.

Another controlling factor is education. Take Kansas, for instance. That state has been dry for thirty years and all through it the two last generations have been trained in a world in which there were no saloons. In Kansas the amendment works.

In Rhode Island, on the contrary, there was no prohibition law before the amendment and as yet the state has not ratified the law; as a result, Rhode Island has never been trained to prohibition and the law works as little as may be within that state. Of course, in Rhode Island the great foreign born and industrial population has much to do with the present situation. No locality is either dry or wet from any one simple set of reasons.

We are finding, however, that all over the country the demands of industry are on the side of the operation of the law. Employers and business men are generally for prohibition—at least for their employees.

So far as we have conclusions then, they are as follows:

Where race traditions, recent education and industrial demands are on the side of the law, the law works satisfactorily. Where they are not, the wheels of its operation creak from day to day.

Even in the wettest spots social workers believe conditions are better than they were.

This study has been hampered from the beginning by the fact that so few people see facts socially.

If this prohibition study goes further and takes in the rural districts which have not yet been touched, the public health nurses can be of the greatest value in gathering for it material which will be a translation of their experiences and observations into terms of human emphasis.

THE VALUE OF MEASURING RODS IN A VISITING NURSE SERVICE

By Marguerite A. Wales, R.N.
General Director, *and*
Mabel C. De Bonneval
Statistician, Henry Street Visiting Nurse Service, New York City

IN his first volume of "Our Times, or the Turn of a Century," Mr. Mark Sullivan speaks of this period (1900–1925) as an American era "unusually rich in leadership in forceful personalities." In Roosevelt, Wilson and Bryan he believes the people personified their convictions and visualized their aspirations: these men represented a common political mood. The passing of these striking leaders and of other outstanding spokesmen in journalism and education marked, he thinks, a definite turn in political conditions in the country. Likewise new forces were at work in other fields. The working man was finding greater opportunity to make himself heard; if we turn to the realm of "big business" we find more thought being given to its human factors. Where scientific management exists the "one leader" idea has given way to that of the "composite general manager" who brings to the consideration of his problems the advice of the men who are responsible for the carrying through of the program and who are most familiar with the actual working out of the final details.

In the world of nursing too the time is marked by changes. The period over the "turn of a century" was striking in the achievements of some of its pioneers, the pathfinders in the development of a new profession, whose retirement from the active field will bring about a present lack of that type of leadership. Thanks to their efforts we undoubtedly have come into the benefits of an established profession and our group as a whole is able to attain a higher average in educational equipment.

Examples show that the modern attitude is one of scientific study. The executives and board members of visiting nurse organizations formerly had the entire responsibility of justifying to business concerns and to the public the "cost per visit" of the service rendered by the staff, while at the same time they struggled with the problem of shortening the hours and increasing the salaries of the workers. In this new age, the executive and her staff, by a joint consideration of the two problems, have come to an understanding of the common factors involved in their solution. The results obtained from the studies made by the Henry Street Visiting Nurse Service during the past three years indicate quite clearly the value of a more intelligent appreciation of the relation of output to costs on the part of the entire staff, and a new interest has been aroused, especially on the part of the supervisor who is responsible for the daily assignment of work, in the planning of time-savers in travel and record work.

The danger of "speeding up," and thus undermining standards, was kept in mind throughout the study, special emphasis being placed on the importance of maintaining a high quality of work.

How the Study Was Made

Under the guidance of Mr. Wallace Clark (consulting management engineer of New York City), who generously contributed the necessary time for supervision, a program of study was mapped out and undertaken. As the matter progressed conferences between the expert and the supervisors were held from time to time.

Subjects of Study

Since the object of the study was to improve the service, the first consideration was given to such staff problems as the following:

Selection of nurses. This resulted in a revised application blank.
Employment turnover. A study of a year's resignations brought out the fact here that many nurses leave because of physical unfitness; therefore a preliminary health examination was instituted to insure greater stability.
Budget control. (As described below.)
Time study.

BUDGET CONTROL

One of the things we have given too little attention to in the past is the fact that the supervisors in the stations are responsible for spending the budget. Of course there are certain items outside their control, such as salaries, rent, etc.; these are simply listed for their information. But there are certain others, too, for which they assuredly are responsible—drugs, supplies, stationery, postage, carfare, laundry, cleaning, equipment, telephone, gas and electricity—and in addition to investigating these details, the supervisors who assisted in the study received instruction as to working out the "cost per visit" for their centers so that they and their staff, as interest grew, might see the full relationship of the various factors involved.

TIME STUDY

While the question of staff stability and center costs could be discussed to advantage at greater length, the important part of our study so far as this particular discussion is concerned seems to be the time element.

Method of Handling Study. For three consecutive years, Henry Street has studied the nurse's day from the standpoint of the distribution of her time. The method used in so doing has varied slightly each year, particularly since the Report of the Committee to Study Visiting Nursing made work sheets for this purpose available. In general, however, the underlying plan in all the studies was the same.

Source. The principal record used for study was the nurse's daily assignment sheet. The assignment sheet is the sheet on which the nurse records the name and address of each patient, the type of visit made, the time of entering and of leaving the case and other relevant data. On this sheet she also accounts for her entire day, specifying what time she was in the office and what time in clinics or meetings and her time of going off duty.

Time. The time of year selected in the 1924 study extended from February through June. In 1925 March, April and May were used and in 1926, May and October. In no year was the entire work of the service taken but approximately 18,000 visits were used as a minimum for investigation in 1924, and 10,000 in 1925 and 1926.

Procedure. The most intensive and also most extensive study was that made in 1924. Our method in 1925 and 1926 followed this closely so that a description of it as it was during the first period will serve for the three. Our thought (which I think will occur to many who plan such a study) was that the routine of the nurse should not be disturbed; in other words, that all responsibility should be borne by a clerical group. However, after a brief attempt at such an arrangement we discovered the error of our ways and realized that a *personal* part taken by the nurse, even though over only a necessarily brief period, would bring far more lasting effects and better further the end toward which the study aimed than any other procedure. When the nurse herself has to analyze her day and assign one portion to travel, another to office and another to field she immediately becomes conscious of travel and office time as factors in her work and so makes herself a more intelligent part of the undertaking. A minor but not unessential result of having the nurse do an analysis of her own sheet is a more accurate recording. She finds that it is difficult to make a complete study

of her day if she has omitted the time whose importance is perhaps negligible from her viewpoint until she has actual need of it.

However, since primarily we were interested in conserving the nurse's time, we did not require her to keep this tally for more than one week. Pursuing the same line of reasoning, we then asked the supervisors to do the detailed analysis for one week, and after that placed the assignment in the hands of competent clerks.

A work sheet was devised which gave for each individual nurse the number of visits of each type made each day and the time consumed in these and in any other activity. The work sheet proposed in 1925 by the Committee to Study Visiting Nursing gives a very good means for such analysis. It does not however include one item we use frequently—visits by time for each type. This can readily be inserted, however, by entering in the time column the number of visits which consumed such time.

The total of the work sheets for each nurse was transcribed to a total for each center and eventually for all centers of the service.

Results. The results of the tabulations were given in three tables by the Henry Street Visiting Nurse Service as follows:

The first was a study of the distribution of the total time of the nurse's day, showing the length of the working day and the amounts of time distributed to office, travel, etc.

The second was a study of the visits per day and the time spent in various types, including the average time per any visit.

The third showed the percentage of time alloted to various types of work.

When the question of an average time for each type of visit was submitted to the supervisors there was much discussion and a feeling that there was absolute inadequacy in any measure of time relating to individual visits. The supervisors considered each visit unique in its contents because of the peculiarity of each family's situation and reaction to disease. Endless cases were quoted to prove the inadvisability of attempting an average. However, from the results as shown above, we believe it is evidenced that an average is obtainable and is practical, and that the cases quoted are exceptions and do not make this table valueless. If we are at all to budget the nurse's day some average must be used.

Table 1. Per Cent Distribution of Time of Nurse's Day

	1926
Working Day	100.
Field Visits	53.3
Clinic	2.5
Office	16.7
Travel	25.
Conferences, demonstrations, other education	2.3
Miscellaneous	0.2

Table 2. Average Time Expended in Visits of Each Type

NOTE: 1924 study excluded here because of difference in arrangement of visit terminology. Terms used are those recommended in the report of the Committee to Study Visiting Nursing.

	1925 Minutes per visit	*1926* Minutes per visit
Average all types	26.9	27.7
Acute:		
Medical	36.8	34.5
Surgical	39.3	32.5
Communicable	34.9	39.6
Prenatal	35.3	30.0
Post Partum	30.6	29.8
New Born	30.1	29.3
Welfare:		
Infant	17.0	14.7
Child	16.8	15.8
Adult	19.0	17.1
*Venereal	....	15.
*Tuberculosis	34.7	41.0
Chronic	53.2	40.3
Not Home, Not Found	8.2	8.7
In Behalf of	20.4	20.4

* Time here not of especial significance because of few number of visits included in the study.

Table 3. Percentage of Total Field Time Allotted to Various Services

In 1926, our study included figures for the time spent in various services as follows:

	1926
Total	100.0
Morbidity	48.4
Maternity	
Ante Partum	7.2
Post Partum and New Born	36.2
Health Supervision	5.8
Not at Home, Not Found	2.4

Studies Published by Other Organizations

A comparison with other organizations which have made similar studies, will eventually bring us to a standard in some, if not in all of our activities.

Because of its topography, each community must be a law unto itself in

judging the efficiency of its travel time; because of its available funds for clerical service and its requirements in recording each community must also be its own judge of the amount of recording which is compatible with good work among its staff; yet there must be certain minimum standards which a comparison of our work with the results of the studies made in other places, will give us.

An excellent and complete analysis of the Nursing Day of the Cleveland Visiting Nurse Association has now been issued over two periods, the first in October, 1924, and the latest in April, 1926. Those two studies give in detail for each district of the association carefully prepared tabulations of the services rendered, analysis of the various activities, time studies and cost figures.

East Harlem Nursing and Health Demonstration has published in its Cost of a Program of Health Activities, similar figures of interest in the study of nursing activity time. Brooklyn also has a detailed study. No doubt many other organizations have made this self analysis. It is our understanding that one of the principal objects of this article is to stimulate comments and comparisons from other visiting nurse services, and eventually to provide a compilation of results which may help us to arrive at standards. We are giving below the comparison of our results in 1926 with those of the agencies whose reports we have:

COMPARATIVE TABLES

Table 4. Per Cent Distribution of Nurse's Day in Henry Street, Cleveland, Brooklyn, 14 Agencies

	Henry Street (1926)	Cleveland (1926)	Brooklyn (1925)	14 Agencies
Working Day	100.0	100.0	100.0	100.0
Field Visits	53.3	59.4	52.0	44.0
Clinic	2.5	0.7	0.0	8.0
Office	16.7	18.0	18.4	19.1
Travel	25.0	20.9	28.4	25.1
Conference, Demonstration, other educational, and miscellaneous	2.5	1.0	1.2	3.8

Table 5. Average Time Expended in Visits of Each Type

	Henry Street (1926) Minutes per visit	E. Harlem Dem. Minutes per visit	Cleveland Minutes per visit
Average all types	27.7	16.1	26.6
Acute			* Other visits 28
Medical	34.5		
Surgical	32.5	25	
Communicable	39.6		
Prenatal	30.0	25	20.9
Post Partum	29.8	46	29.3
New Born	29.3		29.3
Welfare: Infant	14.7	16	
Child	15.8	11	
Adult	17.1	14	
Venereal	15		
Tuberculosis	41.0		
Chronic	40.3		
Not Home, Not Found	8.7	6	5.8
In behalf of	20.4		9.3

* Includes those listed separately in H.S.S. tabulation.

Table 6. Percentage of Total Field Time Allotted to Various Services

	Henry Street (1926)	E. Harlem Dem. (1924)		Cleveland (1926)
Total	100.0	100.0		100.0
Morbidity	48.4	22.2	*Other.	66.7
			On behalf of Pts.	1.4
Maternity				
Antepartum	7.2	8.6		2.8
Postpartum and New-born	36.2	18.6		28.4
Health Supervision	5.8	47.8		
Not Home, Not Found	2.4	2.8		.7

* Includes those listed separately in H.S.S. tabulation.

Some of the Values of the Studies

Conferences with the supervisors were held from time to time throughout the study. Many of the supervisors brought out the fact that the members of their staff have shown much greater interest in planning their day's work with an idea of cutting down travel time. Some have made suggestions about taking their bags home on certain occasions when returning to the office meant great loss of time.

The supervisors in their regular monthly reports have shown an interest in working out minor studies of their own; a more analytical approach to their problems is manifest. Through better understanding of their responsibilities they have been able to make decisions which previously had been referred to the central office. This decentralization saves much time and wasted motion.

The chief value of the study, of course, has been the new and general interest aroused in problems which relate to the welfare of the whole group and to the good of the service in which each plays an important part. It is easy to drift along and forget that one is a part of an organization in which the efforts of each individual affect the good of the whole. Unless some type of measuring rod can be used the less conscientious worker may be depriving the rest of the group of the shorter hours and better conditions due them.

The figures given in this article are submitted with the hope that other organizations may add their comments and figures as studies are made. In this way we hope to reach a clearer idea of what a "fair working day" should be. Perhaps some one can answer the question of just what proportion of the day the public should expect in actual nursing care given. Can we determine a standard number of visits which can be done in a month with reasonable comfort? The swimmer who finds he uses a certain number of strokes in a given time looks to new ways of perfecting his technique so that he can *comfortably* maintain this rate of speed. The awareness of an attainable standard relieves one of the sense of pressure.

At first it seemed absurd to imagine that a standard time could be established for the time per type of visit, but as we look at the figures of various organizations we find *certain accepted procedures in these organizations make for an average time for each type of visit.*

The figures showing the amount of time given in the various services should be especially helpful in placing new nurses where one center seems to be maintaining a low per cent of welfare and educational work due to high pressure from acute cases.

Interest in the time element must not be permitted to affect our ideal of the quality of the service. This year the staff of the Henry Street Visiting Nurse Service is conducting its own study of the "Content of a Nursing Visit." A committee has been appointed composed of two field nurses (selected by the staff), two supervisors (one selected from their own group and one appointed by the executive group), one executive and one representative public health nurse from an outside nursing organization. A plan was worked out by this committee and each center was asked to discuss what it considered important in the visit content and to send in its recommendations. Each center appointed an "observer" who is to be sent into the field with a nurse in another center. These observers met and discussed the "supervisory sheet" drawn up by the committee. Already many interesting points have been brought out by this group. Great interest has been shown and we expect valuable material. We have barely scratched the surface of the possible results to be obtained from these service studies in which the entire staff takes part.

THE PUBLIC HEALTH NURSE AND THE COUNTY HEALTH SERVICE

From A Nurse's Point of View

By Ann Morrison, R.N.
Alabama State Board of Health

The first of a series of articles on the nurse's place in the county health unit.

THE historic and administrative features of the County Health Unit are adequately set forth by Dr. Ferrell in his article "The Public Health Nurse and County Health Service" which appeared in the June, 1926, issue of The Public Health Nurse; therefore I shall confine my remarks simply to the part of the county program which concerns the nurse of the county organization.

The advent of the county health unit in any county arises from a community need and desire. The economic value of it has been long discussed and often the appropriation has been secured only through careful counting and spending of dollars. Usually the organization occupies the entire field of public health within the county and draws its support from the local appropriating board, supplemented by state funds. Thus the work becomes of vital interest to every citizen of the county and has the air of belonging to the people. Because of this it is necessary that the initial steps of health workers be interpreted very carefully and the "reason why" stated simply and patiently in an effort to overcome established prejudices and superstitions.

A Varying Program

The public health nurse who goes into a rural county to work, finds herself confronted with problems very different from those of a large city. Almost always she will find scattered villages and small towns, isolated farm houses and country schools. Consolidation is rapidly eliminating one room schools but we still have dozens of them apparently hiding from discovery, some in the mountains and some in the "piney" woods, and these the nurse must find and visit. Of the network of roads which hold the dwelling places together many will be almost impassable during certain seasons of the year, though, since practically every county has at least a few miles of good highway, there is usually a thrill for her when, emerging from the mire of "byways and hedges," she sees before her a stretch of decent travel. Few are the public health nurses who will never have to turn off the main thoroughfares. Back into the mountains they must push, through woods and miry swamps, over hills slippery with wet clay or deep with sand with little heed to the weather conditions so long as there is work to be done.

Given a large and virgin territory such as this to work in, the question is often asked, "How does the nurse proceed with her generalized program?" Because of limited time and the extent of the area to be covered the program is principally one of health education and varies with the season of the year and with different localities. If the nurse goes to her county in the fall, she usually begins with school work, since through the schools she can work back into the homes. She assists the health officer with the physical examination of the school children and through her follow-up visits into the homes of the children she will discover others in the family needing her services and advice—the prenatal mother, the sick malnourished baby, the preschool child who has not been vaccinated against smallpox and perhaps is otherwise neglected physically, the postpartum mother, the case of active

tuberculosis and sometimes, particularly in counties of the southern states, whole families suffering from heavy hookworm infestation. Again, if she goes to her county in the spring or summer she may begin with the maternity and infancy part of the program. Once begun there is never an end of work to be done; the public health nurse is too well fitted to make home contacts and give home instruction by her knowledge of matters which affect the proper care and treatment of her patients and the general welfare of the community.

The successful nurse has to know country people and talk in terms which they will understand. It is often desirable for her to organize groups for instructive purposes, various types of conferences, or classes for midwife or other instruction. It is always a source of satisfaction to a health officer and nurse to know that fathers and mothers have been sufficiently interested in what the "health doctor" and nurse have to tell them to walk for miles over sandy, dusty or muddy roads with babies in arms and other children trudging at their heels, in order to hear it.

The county health nurse is expected to use an automobile in her work. Some state organizations have found it mutually advantageous for the nurse to purchase and own her car and receive an allowance from the county budget to cover its upkeep and depreciation.

Training on the Ground

Not all county nurses have had training in a school of public health; it is sometimes necessary for an official state agency to take nurses on its staff who have had little or no previous training or experience in public health work. To compensate in a measure for this lack of training it has been found valuable to send the inexperienced rural nurse to a county where the work is already well-organized and under the direction of a trained health officer. For this purpose territory presenting as many public health problems as possible is selected in order to familiarize the nurse with as many and as varied activities as she will be likely to meet. In Alabama the International Health Board has established a training base for health officers. Here the nurse and doctors are brought under the influence of the same type of educational experience. This has helped to reduce dissatisfaction and possibly other friction between the health officers and nurses after they are established in a

Health Officer, Sanitary Inspector, Secretary and Miss Morrison—a Typical County Unit.

county. The nurse trainee remains at the base for one, two or three months observing and assisting in the daily program. Three months is usually the more desirable length of time but it varies with previous training and experience. To the casual investigator this would seem a rather expensive plan, and it is expensive. Like the trial and error method it is far from ideal but it is much better than no training at all and is an improvement over purely theoretical training without observation or practical experience under supervision in the rural field.

It has been clearly demonstrated in several sections of the country that the maintenance of a county health unit is a real economy.

SUPERVISION OF FIELD NURSES

By Jane C. Allen

General Director, National Organization for Public Health Nursing

Given at the Fourth Annual Conference of State Directors of Maternity and Infancy Work, January 11–14, 1927, The Children's Bureau, Washington, D. C.

SUPERVISION of field nurses has peculiar pertinency at a conference of workers in maternity and infancy care held under the auspices of the Children's Bureau. All too frequently the programs supported by Sheppard-Towner funds are carried on in the lonelier sections, which means isolation for the nurse, so that supervision becomes a matter of great importance.

It is significant that public health nursing has now apparently reached that stage where attention is beginning to turn to some of the finer phases. Public health nurses, singly and in groups, are beginning to see more in their jobs than a routine of assigned tasks. An increasing number of public health nurses are to-day seriously studying public health nursing procedures. We have been so engrossed in meeting our urgently pressing needs that until very recently we have not had time to give to a much needed analysis of purposes and functions, and of all the functions involved in public health nursing, supervision is perhaps just at the present receiving the greatest attention. We are beginning to sense the wide range of possibilities it holds for strength and efficiency of service, for economy of time, effort and funds and for the development and growth of our nursing staffs.

There are, however, many different ideas as to what constitutes supervision. The prevalent one is the traditional one of a routine "checking up," a more or less autocratic surveillance for the purpose of getting the work done efficiently and expeditiously. It is this kind of supervision the majority of nurses worked under in their schools of nursing. We were submissive to it as a part of our necessary training but it left in us a desire to avoid a similar relationship whenever possible. Under such autocratic supervision, the nurse was only a means to an end. Initiative and independent thinking and action were discouraged. Little consideration was given to her own growth and development. The work in hand was the main object. And to the average public health nurse to-day, except in a comparatively few larger centers of public health nursing, the term supervision carries with it this more or less unpleasant reaction. It may be vague and indefinite in her own mind. She may have experienced a form of supervision which was less autocratic but still the old hang-over persists. It is well thus to remind ourselves of the underlying reasons for the prevalent attitude of public health nurses towards supervision which all in theory approve but which many in practice seek to avoid or, at best, only tolerate.

The New Supervision

However, with this in mind, it is perhaps fortunate that of all the recent constructive thinking on public health nursing, there is none more encouraging and hopeful than the newer interpretation of supervision. We have now begun to look upon this function as an educational one which means a revolutionary change in our methods and technique. We are finding ourselves obliged to restate our purposes and aims for this particular function and in consequence looking at our staff nurses and our programs of community service in entirely new relationships.

Efficient and acceptable field work still remains our ultimate aim, but many of us now realize that the best way to accomplish this is to regard the

field nurse, her growth, her development, her self-expression in her job, as a specific aim also. The strategic focal point of attention has become the nurse herself—the nurse as an individual with latent possibilities for the development of new powers, the nurse as an intelligent, thinking being with an inalienable right for self-expression and personal initiative. We see the supervisor, on the other hand, as teacher and guide, keeping in the background as much as possible but at the same time with no smallest detail escaping her; ready to help make the weak places strong, making sure that standards are maintained and that the program is efficiently carried on, and constantly awake to new opportunities.

Factors in State Supervision

Field supervision of public health nurses as a state function, while in principle the same, does necessarily differ somewhat from that of a close knit city staff. In the state the factors of distance and time enter in. With the nurses scattered over a large area, many of them isolated workers, the problem is largely one of how to keep open the channels of communication and understanding. On the one hand, there is the need for the supervisor to keep herself fully informed and sympathetic with the local situation, its problems, its resources and its strategic opportunities. She should make it possible to know the nurse as an individual in order that she may appreciate her special needs and her possibilities for development. On the other hand, the local nurse must be encouraged to turn to the supervisor for needed help.

In addition to this all-important relationship, there is a definite supervisory responsibility for linking up the local nurse and the local program with the larger groups and programs, state and national. In this we find the coordinating function of supervision. Here lies the means for establishing standards and for securing that united effort toward the attainment of a common goal which we are more and more recognizing as of fundamental importance in the modern health campaign.

These, then, are the immediate needs:

A supervisor well informed as to local program and local nurse.

A cordial and sympathetic relationship between supervisor and nurse.

Open and well-used channels of communication.

Coördination and unification of nurses and programs as a whole.

The Supervisor and the New Nurse

It may be helpful to consider some practical means for meeting these needs. First of all, good supervision requires a carefully worked out and executed introduction of the new nurse to the field. To permit a new nurse to begin her work without a proper introduction is unfair to her, to the community and to the program as a whole, to say nothing of the handicap which it furnishes in the establishment of desirable supervisory relationships. If she is new to the state, she should spend several days at supervisory headquarters where she follows a definite schedule of contacts and makes a general study of resources and standard procedures. She meets the staff of state workers, she visits the state institutions with which she will have future contacts, she learns something about the development of the public health program in the state, the principal laws relating to health and disease, past and present problems, plans for future development and present standards. She familiarizes herself with facilities in the State Department of Health, regulations governing the control of communicable disease, the laboratory service, the publicity program and how it functions in relation to local workers. She is instructed as to records and reports and is given general information as to the public health nursing program for the state. Thus, before she proceeds to her own particular field of work she has become somewhat oriented and has been made an intelligent member of a state group.

The second half of the introduction should take place in the local field to which it is desirable that the super-

visor plan to accompany the new nurse. She should spend enough time with her to give her personal introductions to the key people, to make sure that she is established satisfactorily as to living quarters, that some arrangement for office room is made, and to give needed assistance in program.

Such an introduction to the field, covering a period of from one week to ten days, is the best possible guarantee of the kind of supervisory relationship desired. It is a minimum below which no supervisory program should go. Subsequent supervision can be based on this sound foundation as a beginning and consists in the main of strengthening the bonds of contact.

Contacts

Much of the contact is necessarily by means of correspondence. Supervisors of field nurses have to-day hardly tapped the possibilities in this particular phase of their work. Letter writing is becoming an art which a successful supervisor of field nurses needs must develop. To respond unfailingly in a helpful way to an expressed need, to become adept at reading between the lines and sensing the unexpressed need, to be alert and quick to follow a lead and write letters so friendly, so full of genuine interest, so helpful, that the nurse receiving them wants more; these require a real skill and conscientious, careful effort.

The analysis and appraisal of the statistical and narrative reports sent in by the field nurse also present opportunities for supervision. Careful study and evaluation of the individual reports, month by month, will give an insight into the present status of the local program, how much, if any, progress is being made and how the local is fitting into the state program. Properly studied and used, these reports should also prove illuminating as to the nurse herself, her individual needs and possibilities, her weakness and her strength. The successful supervisor makes a constant effort to use her reports.

Having started the nurse out with a proper introduction to the field, and having subsequently maintained contact with her through correspondence and field service reports, there remains the periodic visit as a means of supervision. Considerable thought and careful planning are necessary if this is not to become a superficial, more or less perfunctory and routine procedure. The nurse and her local groups should be given the opportunity to plan in advance for the visit of the supervisor in order that the most satisfying returns may be assured. On the other hand, the supervisor will want to make certain a well-rounded visit which will include all those contacts which the special needs of the nurse and her local program indicate would be helpful. If the right supervisory relationship exists, the field visit will be eagerly anticipated and warmly welcomed. It is at this point that we have one of the observable tests of good supervision, for we now recognize that the right relationship between the supervisor and the field is fundamental to all the other assets we expect of this office.

Insuring Good Standards

Finally, it is a major responsibility of the supervisor to coördinate the field work and to insure certain accepted standards in programs and work. She needs to think of the state program as a whole and to look upon each local program as an integral part of that whole. The question at once becomes paramount as to how to bring about knowledge and understanding and appreciation of each other's work which will mean united effort toward a common goal. This must be accomplished so as not to jeopardize local initiative or to hamper any honest effort to carry out plans best suited to specific local needs. Two ways of doing this have proven successful:

Occasional regional conferences.
Bulletins or news letters issued regularly and circulated throughout the state.

A consciousness of group, of a common interest and an appreciation of mutual helpfulness in solving similar problems are brought about through this exchange of ideas. A wholesome

stimulation of local interest and effort usually follows. Supervisors are justified in expending a good deal of time, thought and energy on such projects for, if rightly managed, they bring rich returns.

Supervisory Qualifications

Granted that supervision as a function in public health nursing should mean all this, the most important factors are, after all, *the supervisor herself and her qualifications for success in her job.* Not tenure of office as a staff nurse, not maturity of years or experience, not education nor technical preparation alone, predestine the good supervisor. In the supervisor as in any teacher that which, for a better name, we call personality, counts for much. The nurse who, in addition to sound academic and professional education and a background of successful professional experience, has the rare gift of leadership, of being able to work harmoniously with others, of understanding and of insight into the needs and promise in others, is the nurse who is, as we say, good supervisory material. She must be open-minded and flexible in her thinking, have imagination and vision, a well balanced judgment and a saving sense of humor and common sense.

Too much emphasis cannot be placed upon the importance of a properly qualified supervisor. We admit she is rare and difficult to find to-day, but now that we are beginning to appreciate her strategic position in the whole scheme of successful public health nursing, we are more and more urging the necessity of definitely selecting nurses who give promise of development and helping them become fitted for this kind of work.

ABSTRACT OF DISCUSSION OF MISS ALLEN'S PAPER

The supervisor must have the utmost belief in and devotion toward her work. In addition she must have an adequate background with theoretical and practical experience. She must not only know how to do her work but how to teach it. In the first undertaking she will need to be familiar with the basic principles and concepts of modern psychology, sociology and philosophy. In the second she should understand how to help the nurse to become habituated to thinking while learning by doing. She must instruct her in spontaneous action without arbitrary restraint and inculcate in her desire to follow her lead.

The supervisor must train the supervised to think out problems in relation to the development of a constructive program of work. Criticism of any points should be made from a constructive angle and talked out by the supervisor and supervised in an impersonal attitude. The ability to lead on the part of the supervisor is nothing if it is not joined to the ability to implant a faith to follow. An honest, unstinted, impersonal praise given to the supervised is worth mentioning. The reward of the supervisor is automatic. By stimulating development in others she improves and develops her own methods—to take an inexperienced or untrained worker and watch her progress in technique and self-growth is compensation in itself.

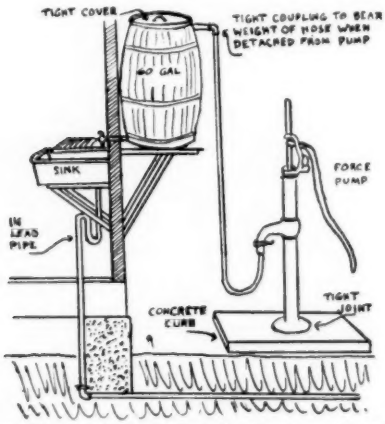
MARY D. OSBORNE
Supervising Nurse, Mississippi

At a meeting in New York of the Foreign Policy Association on *Forward or Backward in China*, Mr. Stanley K. Hornbeck said that his attention had been called to a statement in the Baltimore *Sun* of one of the unfortunate results of revolutionary conditions in China. The *Sun* stated that in China they are executing editors without trial. "Well, what of that?" said Mr. Hornbeck, "Editors have enough trials."

BUBBLERS, FOUNTAINS AND PUMPS

Inexpensive Water Systems for Rural Communities

A NUMBER of questionnaires submitted to farm women as to what is their greatest material hardship has brought forth the almost unanimous answer, the securing of an adequate water supply. To this verdict the county nurse will hardly take exception. Correspondence with more than one worker in the rural field brings out the fact that water is a usual problem both in the school and in the home. We have collected a number of partial solutions in the form of equipment to insure a sanitary drinking supply and submit them here for the interest of whoever may be looking for such suggestions.



A Simple Water Supply System for the Farm Kitchen

Reproduced from "*Hygeia*"

The Child Health Demonstration Committee reports a simple contrivance made for the rural schools in Rutherford County, Tennessee, with the specific recommendation that it has been made for only $7.50. It was the work of a local tinsmith and its construction is obviously simple. It includes a 22 gallon covered can, made sufficiently tall to allow for a good drop, a cock and a waste pipe. It has been further suggested that a stool with a lower platform to hold a waste pail would be an improvement. This model seems to be quite satisfactory and can be obtained, ready-made and at an increased price, naturally, from a number of commercial firms. Where a bubbler is desired and it is not feasible to pay for a commercially manufactured fountain, such a container may be designed locally (a milk or ash can would serve) and fitted with a bubbler. Various styles of the latter can be bought for comparatively low prices. The best design, of course, is that which makes it impossible for the drinker to touch the fountain with his lips and which is made without sharp angles or grooves in which dirt may lodge. Another interesting method proved successful in Anderson County, South Carolina, is designed to connect with an outdoor pump. It is useful because it will allow a number of children to drink at once. It is called the "flute" system and its total cost is not over $30. It is described with illustration and diagram in the September, 1925, PUBLIC HEALTH NURSE.

Such types of water coolers of course are designed chiefly for schools. The question of the water supply in the farm home is not so easily settled and is similarly one of public health. A recent issue of *Hygeia* contains outlines of schemes for conducting water from the well to the farm kitchen and for disposing of waste which show a considerable improvement over the usual methods. One waste disposal system depends on the connection of a rubber hose through the house wall to a covered barrel mounted on wheels outside. This does away with possible breeding places for mosquitoes in puddles of waste and can easily be handled in emptying. Another arrangement is a force pump in a driven well to raise the water to a tank mounted at sufficient height outside the house

to give it a good pressure. It is suggested that a burnt out kerosene barrel can serve very well for the tank if space about it is packed with sawdust or straw in cold weather to prevent freezing. The pump can of course be operated by man-power, but where the automobile is a customary feature of farm life it seems reasonable to recommend that the Ford engine supply the water. With such a system, and the addition of pipes inside the house, as efficient a water supply can be maintained as exists with a city system. For the disposal of waste a septic tank is the safest arrangement.

BETTER AND WORSE

The *Statistical Bulletin* published by the Metropolitan Life Insurance Company gives, in the January number, some new "Best Records" for 1926 for a number of diseases of major public health interest.

Typhoid fever established a new minimum in 1926, with a death rate of 4.2 per 100,000. Scarlet fever repeated its minimum rate of 3.4. Diphtheria established a new low point with a rate of 9.5. Diarrheal diseases declined to the minimal figure of 10.5, while diseases of pregnancy and childbirth showed a most gratifying decline to a rate of 15.6 per 100,000. Puerperal septicemia and puerperal albuminuria also registered new low points.

The new minimum rate for diphtheria is perhaps the greatest single sanitary accomplishment of 1926. We now know how to recognize susceptibles and how to protect them. Demonstrations in a number of communities have shown, beyond a doubt, that diphtheria can be stamped out. With the increasing administration of toxin-antitoxin to school children and to those of preschool age, the outlook is indeed good for the virtual control of this disease.

The rate for accidental drownings dropped to 6.3 per 100,000, the lowest ever recorded, while accidental burns registered a rate of 6.1.

The Other Side of the Picture. Cancer caused 12,830 deaths in 1926 with a rate of 74.9 per 100,000. This is the highest death rate ever recorded for this disease among Metropolitan industrial policyholders. Cancer is the outstanding bad spot in the public health record of last year. The most recent research has demonstrated, beyond doubt, that the general tendency of the cancer death rate is upward.

The death rate from diabetes was the highest since 1922. With the inauguration of the insulin treatment in 1923, there was a gratifying drop in 1923 and 1924 in the diabetes death rate. It was hoped that through the increasing use of the insulin treatment, the declining tendency would persist. We must now, perforce, conclude that the use of insulin has not effected any lasting favorable change in the death rate from diabetes. It is possible, however, that but for the extensive use of insulin, the rate would have increased much more rapidly than it actually has.

Six hundred thirty-eight deaths were charged to alcoholism in 1926 as compared with 485 in 1925.

There has been no appreciable change in the mortality from fatal accidents during the last four years, but another rise must be reported in the death rate for automobile accidents.

Readers interested in arriving at an international viewpoint on the questions Mrs. Bruère discusses in such timely fashion in this number will appreciate this contribution:

An English innkeeper recently posted this notice in his bar:

Two pints make one quart;
Four quarts make one gallon;
Two gallons make one argument;
One argument makes one quarrel;
One quarrel makes one fight;
One fight makes two policemen;
One magistrate, one policeman
And one magistrate's clerk make
Twenty shillings or fourteen days.

He appended this further advice to his followers: "Call frequently; drink moderately; pay honorably; be good company; part friends; go home quietly."

NURSING IN RELATION TO THE THREE PLANS SUBMITTED FOR MUNICIPAL HEALTH DEPARTMENT PRACTICE*

These papers give the substance of the discussion of the Second Session on Public Health Nursing at the Fifty-fifth Annual Meeting of the American Public Health Association at Buffalo, N. Y., October 14, 1926. Sophie C. Nelson, Fellow A.P.H.A., Director of Nursing Service, John Hancock Mutual Life Insurance Company, was Chairman.

ANALYSIS OF PLANS

W. F. WALKER, D.P.H., Fellow A.P.H.A.
Field Director, Committee on Administrative Practice,
American Public Health Association

THE plans for municipal health department organization have been developed largely from studies of current health department practice during the past six years. In 1920 a study of large cities (those over 100,000 population) was made under the auspices of the Committee on Municipal Health Department Practice. As a result of this study Professor C.-E. A. Winslow, chairman of the committee, in compiling the report included a description of an ideal health department for a city of 100,000,[1] drawing freely from the experiences of cities that had developed workable organizations. The plan of organization for cities of 50,000 population[2] was based upon the experience gained by the American Child Health Association from its survey of health activities in 86 cities ranging in population from 40,000 to 70,000. Likewise the plan for a city of 20,000 written by Professor Ira V. Hiscock[3] was based upon a study of 21 towns of from 10,000 to 30,000 population.

These suggested plans of organization were subjected to trial and criticism by health officers throughout the country and an attempt made to bring out specific criticisms and suggestions relating thereto at the American Health Congress. At the same time a basis was laid for the development of a plan for rural or county health work. Using the material at hand, and seeking the advice of outstanding men engaged in public health administration in communities of these various sizes, the Committee on Administrative Practice brought together these suggestions for desirable organizations.

A common objective has been assumed and a program of health activities standardized, as far as possible. It is my purpose to give you outstanding facts of the nursing service contemplated in these three plans, namely,

The consistency of thought.
The variation in extent and intensity.
The changes in staff made necessary by the size of the community.
Other pertinent facts bearing on the nursing service.

In considering each plan the size of the community must be kept in mind:

Plan I—City of 100,000.
Plan II—City of 50,000.
Plan III—Community of 30,000 (20,000 urban and 10,000 rural).

The nursing staff suggested for these plans is shown in Table I.

TABLE I
NUMBER OF NURSES

	Plan I	Plan II	Plan III
Chief	1	1	1
Supervisor	5	2	..
Special Supervisor	2	..	..
Staff Nurses	44	22	5
Total	52	25	6
Population per Nurse	1923	2000	5000

It will be noted that the intensity of nursing personnel is approximately the same in the three plans. It is slightly greater for the smaller community, though this increase is probably not

* This discussion appears simultaneously in the March number of the *American Journal of Public Health.*

equal to the increased time required to administer the rural aspects of the service. The small staff calls for more highly trained and better qualified personnel. The supervision of the service requires a person with broad experience, thoroughly familiar with the details of the several activities carried on.

TABLE II

	Plan I	Plan II	Plan III
Total Budget	$86,190	$44,800	$11,500
Per Capita Cost	.862	.896	.383
Per cent of Total Health Department Budget	.397	.494	.273

The per capita cost of the nursing service and the proportion of the total health department budget devoted to this activity as shown in Table II, presents interesting relationships. The per capita cost for nursing service in the smaller community is about one-half of that estimated for a community of 50,000.

The proportion of the total health department budget expended for nursing is higher in the small city (50,000) since certain other services are not required to be developed so extensively as in a city of 100,000 and more. This is particularly true of laboratory service, communicable disease control, tuberculosis control and sanitary inspection service. In the rural community the proportion of total expenditures for nursing service is considerably less than in either of the other groups. This is not to be construed as the ultimate division desirable, but as what is proper, considering the state of rural work.

The distribution of nursing time in the various services, depending upon whether bedside care is a function of the service, is shown in Table III.

TABLE III

DISTRIBUTION OF NURSING TIME

	Plan I		Plan II	
	Without Bedside Per cent	With Bedside Per cent	Without Bedside Per cent	With Bedside Per cent
Communicable Diseases	15.4	8.8	15.4	8.9
Tuberculosis	9.1	5.2	9.3	5.3
Venereal Disease	3.7	2.1	3.9	2.3
Prenatal	26.1	14.9	24.5	14.0
Infant	17.5	10.0	18.0	10.3
Preschool	4.0	2.3	4.1	2.3
School	24.2	13.8	24.8	14.3
Bedside	..	42.9	..	42.6

Plan III

	Per cent
In patients' homes	28.0
In district health conferences	30.0
In school and clinics	11.0
In staff meetings and coöperative visits	10.0
In travel	21.0

The distribution of nurses' time for Plan III has not been worked out as for I and II, and though it may not be ideal it is suggested as one which may be workable at the present time.

The stage of development of the nursing service will influence to a considerable degree the time distribution in a particular area. As activities become better established there is a necessity for reorganization of the nursing time, but the distribution suggested is based upon a uniform stage of development of all activities. Delivery and postpartum nursing care are included in the per cent allotted to prenatal care. The allotment for bedside care carries with it a considerable amount of educational time which may influence other activities.

A number of cities are carrying out some part of the program to the extent indicated. There is no instance at the present time where a city has adopted the program *in toto*. One must look at the combined picture of public and private efforts. Inability to point to a specific instance of a complete adoption of such plans does not indicate the undesirability of individual features based upon average community needs.

[1] *Report of the Committee on Municipal Health Department Practice, Pub. Health Bull. No. 136,* July, 1923.

[2] *A Health Survey of 86 Cities.* American Child Health Association, 1925.

[3] *The Organization and Budget of a Health Department in a City of 20,000 Population.* Ira V. Hiscock, *A. J. P. H.,* 14:3, 203 (Mar.), 1924.

DISCUSSIONS OF THE THREE PLANS

IRA V. HISCOCK, FELLOW A.P.H.A.

Assistant Professor of Public Health, School of Medicine, Yale University, New Haven, Connecticut

I SHOULD like to explain somewhat briefly how we arrived at these estimates of nursing requirements which Dr. Walker has presented to you. In the original plan of health organization, the number of nurses needed was calculated on the basis of 1 nurse for approximately 2,000 people. At the time this plan was prepared there was practically no information suitable for use as to the length of time required for a given type of nursing visit. Relatively little had been done toward the establishment of standards to indicate the number of nursing visits of various types which should be made in the average community. Certain questions arose, therefore, concerning the suggestion that there should be 1 nurse for every 2,000 people.

Recently, however, there has appeared a valuable report from the East Harlem Nursing and Health Demonstration in New York City, which shows for the district studied the length and cost of a visit in the home according to the type of service rendered. In making use of this report, we have consulted leaders in the nursing group and health administrators. Many helpful suggestions have been received from the National Organization for Public Health Nursing, and representatives of state, city, and voluntary organizations.

The report to which reference has been made shows that 51.6 minutes on the average are spent in connection with a home visit. On the average, 16.1 minutes are actually spent in the home, the remaining 35.5 minutes being spent on records, in supervision, general office work, travel, staff meetings, and miscellaneous activities. But the length of a visit in the home in connection with postpartum and newborn cases is 46 minutes on the average, as contrasted with 10 minutes with a school case.

Example—A specific example may be helpful in making clear the exact procedure followed in this revised plan of health organization. If it be assumed that in the average city of 100,000 people, the birth rate is 24, then there will be 2,400 births in a given year. *The Appraisal Form for City Health Work* suggests as a reasonable standard of field nursing service for infants under 1 year of age, that there should be 4,000 home visits per 1,000 live births. In the city of 100,000 population, then, there should be 9,600 home visits. To make these visits, each of which would consume 51.5 minutes (on the average), would require a total of 8,240 nurse hours for the year. In addition, there should be 2,500 infant clinic visits per 1,000 live births, and this would require 480 additional nurse hours, making a total of 8,720 nurse hours in connection with the care of infants under 1 year of age. If it be assumed that, on the average, there are 250 working days of 8 hours each, allowing for vacation, and so forth, a single nurse may be counted on for 2,000 hours of work in a year. In a similar way the total amount of time and nursing personnel may be determined for each type of activity, as prenatal, school, and so forth. To the total staff nurses (44) required must, of course, be added supervising nurses (5), including also a mental hygienist and a nutritionist.

It is interesting to find that the total number of nurses required as calculated on this basis compares very closely with the number earlier suggested by Professor Winslow. One of the chief differences is that the earlier plan called for only 1 communicable disease nurse, whereas the present plan calls for 4 nurses. Certain minor deductions for other types of work tend to balance this.

You may rightly question our application of data derived from a demonstration in a large city to this proposed plan. It is true that the situation in the East Harlem Health District is somewhat unique. But upon careful consideration of various aspects of the problem, it has seemed to us that the source of error is not large enough to be significant. Our previous estimates concerning nursing time have, for the most part, been based upon the assumption that a nursing visit in a city on the average requires one hour. The average figure for this study quoted is only slightly less than this, and the figures have the added virtue of differentiating between different types of nursing visits to show, for

example, that it takes nearly twice as long in a home to make a postpartum visit as it does to make an antepartum visit. Hence, we have taken these data, with certain reservations, because they seem to answer fairly well our needs, and they are the only data which have been presented in such detail, so far as we are aware, for this purpose.

EUNICE H. DYKE, R.N.

Director of Public Health Nursing, Department of Public Health, Toronto, Canada

THE background for these conclusions is a municipal nursing service which has developed during the past fifteen years through tuberculosis, child welfare, a combination of the two and the inclusion of hospital social service and school health service, up to the present organization which includes all the public health nursing services of the city with the exception of industrial nursing and bedside nursing. A splendid national nursing organization has a local branch with 45 nurses giving bedside care on a fee basis. The city nurses, totaling 114, are organized in 10 service units, 9 district groups, and 1 group of 15 nurses assigned to the hospitals but working through the district offices. Included in this staff of 114 are a director, assistant director, 9 district superintendents, a superintendent of hospital social service and 4 functional supervisors. Each field nurse has a small district in which she gives all types of service.

The results have proved that a sympathetic and effective contact can be made with the homes by public health nurses who *may not depend upon the incident of illness* for an entry to the homes.

Coördination of bedside nursing care with the general health services will be considered if the visiting nurse association decides that it is essential to the community that the health services should be strengthened by the teaching opportunity offered by bedside nursing.

A Completely Generalized Service

Arguments in favor of a completely generalized service:

> The nurse whose service ends with the patient's illness realizes her opportunity to use that illness as a basis for constructive work in the home. The nurse who is not permitted to give bedside nursing care frequently longs for the opportunity to give a tangible service which would dispel barriers between her and many homes needing her knowledge.
>
> City Councils who reflect the sentiments of the taxpaying public will grant money more readily to the organization giving nursing care in illness than to the organizations refusing that care.

When the public seeks health service from the private physician, and when he is prepared to give that service, we may expect a higher standard of public health. The leaders among private physicians, the medical schools and many departments of public health are working toward that end. When the public health nurse who has worked under the private physician's orders during a patient's illness may continue to visit the home which needs the supervision of a health nurse, we may anticipate that she will influence the family to seek the advice of the family physician more frequently. The present need for an educational service apart from the private physician, is resulting in a questionable growth of health centers.

The proposed organization would provide service in sickness and in health, simplifying the situation for the general public, social workers, hospitals, and physicians. It would not be possible in a crowded city to arrange for every nurse on the field staff to carry, unaided, the full service for her district. In normal times, the nurse in a suburban area could probably do so with the exception of the occasional case of critical illness and the confinement service.

The community with district offices and a superintendent of nurses in each office, would leave her to adjust the duties of her individual nurses. The majority of those nurses would have clearly defined areas within the district. One or more nurses would be retained as "floats" to make the urgent visits which could not be made by the family's own nurse. At certain times of the year, and during epidemics, it might be desirable to increase the number of floats rather than to rearrange the small district with resulting dislocation of neighborhood contacts. It might not be wise to attempt a completely generalized service with a fixed staff.

Sources of Income

The sources of income would vary in each community. An agreement would be reached as to which of the services should be paid for from the public purse and which from the private purse. A coördination of committees representing public and private agencies would be necessary. In the majority of communities, bedside nursing care, which normally would be given by a member of the family, would not be paid for from the public purse. The taxpayers in some communities are already prepared to pay for all other nursing services. It is essential that the policy regarding payment should apply to all classes, since a distinction with respect to bedside service in favor of the poor and the ill-informed might result in a limited use of all types of service by the more favored classes. Money collected for services not assumed by the public purse should be collected on an individual fee basis from the patient or his friends, from the insurance company, or from a social agency interested in the patient.

Determining the Cost

The actual cost of an hour of nursing time having been ascertained, the nurse's daily work report would provide the accountant with information from which accounts could be sent to the department of public health and to the private organization which had accepted responsibility for certain types of nursing care. That organization would then collect from the patient, insurance company or social agency, using the hour as the unit of cost.

The educational value of this method of accounting and of fee collection would become apparent if the future should bring consideration of social legislation requiring general knowledge of the cost of high grade medical and nursing services.

Since the cost of an hour of service would be determined on the basis of a normal working day, income derived from overtime service would not be required for the maintenance of the organization. This income would indicate the need for additions to staff. When not used for that purpose, it might be returned to a council of the nurses, to be used for staff projects suggested by the nurses' council and approved by the governing board of the administration.

The governing board would necessarily combine the interests of public and private agencies since both provide the income. If essentials are guarded, the administration might be under either public or private control.

Essentials of Administration

1. The governing board should represent both public and private agencies.

2. A high grade executive staff is required. Too much emphasis cannot be placed upon the leadership required of the district superintendent. Functional supervisors should not intrude upon her responsibility or be appointed to deal with special functions unless the need is clearly proved.

3. All services should be available for the privileged as well as the underprivileged. Bedside nursing care should be provided on an hourly fee basis.

4. Provision should be made for additions to the staff when there is a rise in the incidence of disease requiring bedside care.

Directing a Generalized Service

Direction of a generalized community nursing service by the public agency is desirable for the following reasons:

1. The public agency can bring about coordination of public and private agencies, and delegate functions, but it is difficult for representatives of a public agency to participate in work directed by a private agency.

2. The nursing service of a public department makes articulate that thing in government which lies buried in the heart of every alderman.

3. The nurse who visits the homes as a representative of government can interpret the essential qualities of government where all other influences fail.

4. The public health nurse employed by the people whom she serves finds the relationship a happy one. She is particularly happy when she may interpret the needs of her clients to intelligent philanthropy.

Recognizing the nurse as an influence for the advancement of social welfare, we covet for her the strategic position of a public employe.

(*To be continued.*)

SUGGESTED PROGRAM FOR TUBERCULOSIS COMMITTEE OF THE FEDERATION OF WOMEN'S CLUBS

Editor's Note: The following program for women's clubs prepared by the National Organization for Public Health Nursing at the request of the Chairman of the Public Welfare Department, General Federation of Women's Clubs, is suggested by the Tuberculosis Committee of the Federation and accepted by the Chairman of Public Health and her adviser on Tuberculosis of the General Federation of Women's Clubs.

Although some of the suggestions seem very general, it is important that women's clubs get a picture of this problem as a whole. While it would not, in all probability, be possible that the entire program could be carried out in one or two years, it is suggested that the committee chairmen, working with the health officer and the local tuberculosis association, study the local situation in order to find out what part of the program can be successfully carried out during the first year. It is also suggested that special committees or groups of the club be appointed to study the various parts of the program. The type of intensive study recommended as the first step in the program given will enable club women to realize the aims and purposes of the organizations now encouraging promotion of health and prevention of disease throughout the country.

I. Undertake intensive study of the principles underlying individual, family and community health through the formation of health study clubs under the direction of leaders equipped to teach these subjects. Such leaders will be recommended by the various State Tuberculosis Associations and outlines for courses of study can be obtained without cost from the same source. Textbooks also can be secured for a nominal sum.

Such intensive study will not only be found interesting and personally helpful but will help the club members to evaluate present health practices and proposed health measures and legislation.

II. Know proposed health legislation, both state and local, and give loyal support to those bills which are sponsored by leading health authorities.

III. Find out the aims and methods of disease prevention and health promotion of all local and state agencies both public and private which in any way touch the health of the community. Learn the reasons for each measure and stand back of each, not only through personal volunteer service when this is needed, but through interpretation of these measures to friends.

Far more can usually be gained by loyally supporting the work of constituted health agencies than through independent action.

IV. Stand back of all movements which aim

To provide a safe and clean milk supply.

To prevent the spread of infection, such as measures for prevention of promiscuous spitting, coughing, and sneezing.

To check the spread of communicable diseases by immunization measures, as in smallpox and diphtheria.

To promote healthy environment, such as open windows, clean homes and streets and the like.

V. Support especially all measures which aim to find early, contact, or suspected cases of tuberculosis, especially among young children and among adolescents.

One of the best means of accomplishing this is by periodic physical examination of all age groups by competent private physicians or through clinics and conferences provided for those unable to pay a private physician and by organized medical school inspection.

VI. Find out the extent of the tuberculosis problem by comparison of local death and sickness rates from tuberculosis with similar rates for the state and county.

VII. Find out the approximate number of arrested and potential cases of tuberculosis. Authorities agree that for every death from tuberculosis there are approximately nine active and nine inactive cases.

VIII. Find out from this data the interest of local physicians and health authorities in reporting cases. Only by adequate reporting can these cases be helped and the community protected.

IX. Find out the attitude of local physicians toward periodic physical examination and other preventive measures. Encourage and stimulate all efforts to secure application of these health measures.

X. Find out the present facilities; support existing agencies in making further needed provision and the continuance of support for—

Diagnosis and care of cases through
- a. Chest clinics (these may be in connection with a hospital, a dispensary or separately administered).
- b. Hospitals or sanatoria for the care of advanced or early cases.
- c. Public health nursing service for home care and instruction.

Care of contacts and physically sub-standard cases through open air schools or classes, preventoria or summer camps, and through home supervision by the public health nurse.

Health supervision and health instruction of the prenatal mother and of all age groups through the private physician or medical and nursing conferences and by the public health nurse in the home and in the school.

Health teaching and training of children in public and private schools.

Detailed information as to the actual facilities needed can be secured from the Health Officer and the state or local tuberculosis associations.

IS THERE A NURSING SHORTAGE?

About the time this magazine reaches our readers, the Committee on the Grading of Nursing Schools will be in the midst of a gigantic inquiry into the truth about the nursing shortage. In Massachusetts, New York, Pennsylvania, Georgia, Louisiana, Illinois, Kansas, Wyoming, Washington, and California, questionnaires are being sent out to nurses by the Grading Committee, the first real effort to get at truth about the supply of and demand for nurses. Some nurses and doctors believe emphatically that there is no shortage in any real sense of the term. Others, equally competent to judge, declare that there is actually a very serious shortage. This is an effort to find out the facts. Please help the Committee by answering the questions that may be asked you.

The Committee is canvassing private duty, hourly, public health, and institutional nurses; superintendents of nurses in hospitals; directors of public health nursing organizations; heads of registries; physicians and surgeons; and through them many thousands of patients. The questions are simple. They can be answered in ten minutes. No names need be signed, but in each case the writer is asked to give a full and frank expression of opinion on the back of the sheet. We wish to emphasize that if this study is to be a success it must be taken seriously by the people to whom the questionnaires are sent. We appeal for your coöperation.

The Committee on the Grading of Nursing Schools.
William Darrach, M.D., Chairman.
May Ayres Burgess, Ph.D., Director.

TRACHOMA AS A NATIONAL PROBLEM

A SPECIAL session of the Twelfth Annual Conference of the National Committee for the Prevention of Blindness was devoted to a discussion of trachoma. The program was divided into the following four topics:

Prevalence of the disease.
Remedial and relief measures.
Needed etiologic and epidemiologic research.
Measures for eradication which may be safely urged.

On each of these there was expression of a number of viewpoints by the specialists who attended. Ex-Governor Hagerman of New Mexico spoke of his experience among the Navajo and Pueblo Indians, bringing a special message of appreciation from Secretary Hubert Work of the Interior, and Commissioner Charles Burke of Indian Affairs. There are, he said, 30,000 Navajos and the incidence of trachoma among them is 20 or 25 per cent outside the schools and 35 or 40 per cent in the schools. From the money accruing to these people from recent oil developments a program for fighting the disease is to be put in effect, a school for segregating children having already been set aside at Fort Defiance.

In slightly favorable contrast is the condition now existent in Minnesota as described by Dr. A. J. Chesley, Health Officer of that state, who said that it has a lower incidence but that due to trachoma's chronic nature and the Indian's unsettled habits it was not possible to get accurate figures. The theory of deficiency disease which may be brought within control, if not conquered, by proper living conditions and well-balanced diet was offered by Dr. J. A. Stucky of Lexington, Kentucky, from his experience among the mountaineers of that state. He spoke of the difficulties in getting fresh vegetables, butter or milk in the mountains and connected these conditions with the corresponding high incidence of trachoma. "I began," he said, "to talk about proper cooking and I would tell my nurses, 'Show these people how to cook.'" He said that he was experimenting with a cereal made of grains obtainable in the mountains and able to be ground in the old-fashioned coffee mill. With that he said he would recommend cod-liver oil when it is impossible to get milk or butter, and emphasized the fact that it is not only possible but beneficial to "eat anything a rabbit eats." Recurrences have not happened when he has established the patient on a balanced diet. In fifteen years, he said, Kentucky had made such progress against trachoma that it seemed to him as if he were now "living in a new world."

Dr. Ezra Sprague, chief medical officer at Ellis Island, pointed out that different physicians may possibly call a number of eye conditions trachoma. Only the incurable kind, he said, is excluded from this country, other sorts being sent to hospitals for treatment.

The discussion of remedial and relief measures was opened by Dr. William Campbell Posey of Philadelphia, who was on the recent trip made through the southwest in the interest of the National Committee, as a result of which the school at Fort Defiance for the segregation of trachoma sufferers was recommended. Dr. Paul D. Mossman spoke of the work of his special clinic at Rolla, Missouri. After-care, he said, is of as great importance as surgery, and proper diet will aid prevention.

The following statement was made by Miss Marion Campbell of Chicago, referring to the year in which the Illinois Society for the Prevention of Blindness conducted demonstration clinics in five counties in the state's trachoma district:

The year of clinical service was undertaken as a result of a study extending over ten years made by the staff of the Illinois Charitable Eye and Ear Infirmary. This study disclosed that a large per cent of the population of southern Illinois suffers from trachoma and has no

means of securing treatment. The plan to institute a series of clinics was therefore endorsed by the State Department of Public Welfare, which bore the major part of the expense, the State Department of Health, the University of Illinois Medical College, the Red Cross and the State School for the Blind, all of which furnished members of the staff. The results have been to focus attention on the problem in each locality where it exists and to make clear the need for effective follow-up measures where provision for treatment itself has been made.

Miss Campbell brought out the following points:

The most thorough work in any clinic is rendered ineffectual unless it is followed up with continued treatment facilities.

In leaving nurses in touch with patients we did one of the most effective things possible toward real and permanent control of the disease.

Dr. Marshall C. Guthrie, chief medical director of the Office of Indian Affairs, presented a statistical report on trachoma among the Indians from 1910 on.

Etiological and epidemiologic studies were the third topic of the conference, opened by Dr. Martin Cohen, who has engaged with Noguchi in research as to the cause of the disease. It is still undiscovered, Dr. Cohen said, but added that he believed trachoma to be only very mildly contagious. He also regards it as practically incurable but able to be retarded.

SUMMARY

In summarizing the data presented by the various discussants for the guidance of the National Committee, it was brought out, apparently with the approval of all present, that we now have between 5,000 and 25,000 Indians and somewhere between 20,000 and 50,000 white citizens afflicted with trachoma in the continental United States with all of its possibilities of serious impairment of vision, potential production of blindness and increase of dependency.

There was agreement among the speakers that to provide remedial and relief measures to so large a number of isolated sufferers was a problem of tremendous size. Most of the clinicians were in agreement that much vision could be salvaged and much suffering ameliorated by expansion of the personnel now in the field. The consensus of opinion favored providing more skilled ophthalmologists and more public health nurses for the afflicted communities. For the Indian service, nurses of Indian blood were looked upon with favor. Teaching the use of well balanced diets and elevation of living conditions and social conditions were favored and by some were urged as of great value in preventing relapses.

The conference discussion plainly indicated that no acceptable causal agent had been proven. Some discussants still believe the disease to be infectious. There was a large measure of agreement that the danger from infection had been greatly overstressed, that if the disease is infectious it is not readily transmitted from one individual to another under decent living conditions. There was entire agreement as to the need for urging further etiological studies and that they be continued until the causative factor be proven, and that broad gauge epidemiologic studies be undertaken in different localities and in different countries aiming to bring out and to evaluate all environmental faults concerned with the development of trachoma.

The consensus of conference opinion for eradicative measures that might now be endorsed favored employment of more ophthalmologists for remedial and salvage work and the employment of many, many more public health nurses for home teaching and elevating social and living standards to a point a little nearer that of the average American family. It was even intimated that education, gainful employment and clean homes are perhaps the real goals which we must seek in our eradicative work.

"Few of the great discoveries of preventive medicine, except for the prevention of yellow fever, are anywhere nearly fully applied," said Dr. William H. Welch, chairman of the Milbank Memorial Fund's Advisory Council, at the fifth annual dinner of the Fund. "New discoveries, utilization of recently acquired knowledge, closer application of accepted principles of hygiene, improved working and home conditions—these are the things counted on to bring about further decreases in the death rate. But much, I assure you, needs to be done in educating the general public in the ways of conserving health."

ACTIVITIES *of the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

Edited by JANE C. ALLEN

JOINT BOARD MEETINGS

During the week of January 17–22 the Boards of the three national nursing organizations met both separately and jointly in New York City. In between the various board meetings, every available hour was occupied with committee meetings.

The outstanding topics of interest during the week were:

1. The Harmon Foundation Plan for Nurses' Annuities.
2. The proposed amalgamation of the *American Journal of Nursing* and THE PUBLIC HEALTH NURSE.
3. The five year study of nursing by the Committee on the Grading of Nursing Schools.
4. The future policy for meeting appeals for aid to foreign nursing groups.

The Joint Boards were unanimous in expressing their appreciation of the interest in the welfare of nurses as shown by the Harmon Foundation in New York City and voted the immediate appointment of a committee of nine—three members from each nursing organization, one of whom represents the employer's point of view, to give careful study to Annuity Plan of the Foundation.

The committees on magazine amalgamation of the A.N.A. and the N.O.P.H.N. met in joint session on January 17 and voted to recommend to the Joint Boards that a general committee, representing all the various interests in nursing, be appointed for the purpose of studying the type of magazine which will best serve the needs of all nurses of America. This resolution as presented by Miss Fox, was unanimously adopted by the Joint Boards.

A third committee created by the Joint Boards is a committee of nine—three from each nursing organization—whose responsibility will be to formulate a workable plan whereby local groups of nurses—state, district, and alumnae—may be approached in the interest of securing substantial contributions to the budget of the Committee on the Grading of Nursing Schools. The five year study which the Grading Committee is launching promises so much of what is vital to the very essence of nursing, that the Joint Boards feel the entire body of the profession will eagerly welcome an opportunity to participate in the financial support of the project.

The fourth important topic discussed by the Joint Boards was a question of international relationships in the nursing profession. Four definite and apparently worthy appeals for financial assistance were presented from four widely separated foreign groups of nurses from other countries. It seemed to the Joint Boards that the American nurses have a responsibility to their foreign sisters but that any response to any appeal should be based on a careful consideration of all the needs of a similar nature. Therefore the Joint Boards voted to refer all such matters hereafter for clearance to the International Council of Nurses.

It was decided that the nursing exhibit on display at the Sesqui-Centennial Exhibition in Philadelphia should be preserved for loan and other exhibition purposes, a small fee to be charged at the discretion of the secretaries of the National Organizations, to cover the cost of transference and wear and tear.

BOARD MEETINGS OF THE N.O.P.H.N.

The business of the quarterly meeting of the Board of Directors centered around the reports of the Standing and Special Committees and of the General Director. The Directors present were, Mrs. Anne L. Hansen, Jane Van de

Vrede, Winifred Rand, Florence Patterson, Elizabeth Fox, Alta E. Dines, Jane C. Allen, Mrs. Chester Bolton, Mary Arnold, Dr. Haven Emerson, Mary Beard, Grace Anderson, Anna Ewing, Carrie M. Hall, Mrs. Helen LaMalle.

The Education Committee, at its meeting on January 15, gave careful consideration to the preliminary questionnaire on the affiliation of schools of nursing with public health agencies which the Grading Committee is sending out this spring. The Education Committee is acting in an advisory capacity to the Grading Committee in connection with the particular study of under-graduate affiliation.

Consideration was also given the question of summer courses for school nurses, and the following conclusions adopted:

1. A year's course in school nursing is desirable and, if the shorter summer course is given, it should be a part of a progressive series.
2. The main emphasis and approach may be from the school nursing point of view but the course as a whole should contain generalized material.
3. Material should be adapted to school nursing needs.
4. A school nurse is justified in entering the public health field through her own specialty.

The General Director was asked by the Committee to gather material on staff education programs while on her western trip. This is the major study planned by the Committee for 1927.

The Publications Committee report outlined the campaign for subscriptions to THE PUBLIC HEALTH NURSE, the main feature of which is the enlistment of the coöperation of group leaders throughout the country in relaying magazine publicity to the individual nurses and lay workers. Attractive folders setting forth the 1927 contents of the magazine have been sent to the state supervising nurses, to the presidents of the State Organizations for Public Health Nursing and of public health nursing sections of State Graduate Nurse Associations. Also to Red Cross, Metropolitan Life Insurance and Tuberculosis regional supervisors with the suggestion that they use every possible channel for making the contents of the folder known to their nurses. Course directors, superintendents of the 500 larger nursing schools, and librarians of a selected group of medical libraries and women's colleges are also being asked to post folders on their bulletin boards. The Committee reported that it also assisted the editor with her plans for the 1927 magazine, especially the new department "Board Members' Forum."

The Finance Committee reported a meeting on January 3 at which the following resolution, for presentation to the Board, was prepared:

That the N.O.P.H.N. continue its present efforts to secure income from contributions and memberships, but that the chief emphasis, from now on, be upon group support as typified by the percentage plan, upon further support from state groups and possibly upon support from industrial concerns interested in the promotion of health.

The Records Committee reported progress on the preparation of:

A daily report form for a generalized nursing service.

A record book for one nurse organizations.

A daily and semester school nursing report.

Future projects include monthly and annual report forms for generalized service, supervisor's report, and nurse's service report. The Committee also hopes to make a study of the filing of records and reports.

The report of the Committee on the Lay Section included the following suggested Two-Year Program:

Letters to lay and corporate members of the N.O.P.H.N., to State Branches and to other organized state lay groups, as a basis of a study of existing groups of lay workers.

Publicity in THE PUBLIC HEALTH NURSE and a general campaign of education on lay participation in public health nursing.

Assistance with the organization of Lay Sections in the S.O.P.H.N's.

A limited number of regional conferences of board members.

The Committee hopes to present a definite recommendation at the next Biennial as a result of its two year study. The Committee also suggested to the Board that the N.O.P.H.N. af-

filiate with the New Haven, Connecticut, Visiting Nurse Association in the Institute for Board Members which is being planned for early this spring. The Board voted to approve this affiliation.

The Branch Development Committee reported a meeting held on January 17 at which recommendations were prepared that:

It coöperate with the Committee on the Lay Section in the organization of lay sections in the State Organizations for Public Health Nursing.

Approval be given the stimulation of lay membership in the N.O.P.H.N. as an indirect encouragement of State Organizations for Public Health Nursing.

Publicity be given in THE PUBLIC HEALTH NURSE to the past accomplishments and present status of existing State Organizations for Public Health Nursing.

The General Director reported among other things already known to PUBLIC HEALTH NURSE readers:

That during the past quarter approximately 5,000 pieces of mail have come into the N.O.P.H.N. office while the outgoing mail has totaled 22,216 pieces, which included 2,000 statistical form letters and 4,800 renewal notices and form letters.

That combination subscription offers with *The Survey, The American Journal of Nursing* and THE PUBLIC HEALTH NURSE have been agreed upon.

That the special study of the business department carried on by Mr. Meyer Handleman during October and November had resulted in valuable advice for increasing efficiency and economy.

The Board voted that it send the International Council of Nurses at Geneva complete sets of THE PUBLIC HEALTH NURSE, suitably bound, and that hereafter at the end of each year a set be contributed.

A special joint meeting of the National Organization for Public Health Nursing and the National League of Nursing Education was held on January 21 for the purpose of hearing the report of the Joint Committee to Study the Needs of a Midwifery Course for Nurses. The following resolution was passed:

That the committee representing these two nursing organizations be directed to make contact with such representative bodies of the medical profession of this country as can be persuaded to coöperate in studying the problem of midwifery service or assistance.

We are assembling a complete file of THE PUBLIC HEALTH NURSE for the International Council of Nurses and we lack the following numbers. We shall greatly appreciate hearing from anyone who has any of these copies to dispose of:

1909—January
" October
1910—January
" April
" July
1912—January
1913—January
" April
1919—January
" February
" December
1920—June
" August
1926—June

In addition, has anyone a complete or partially complete file of THE PUBLIC HEALTH NURSE which she would care to sell?

Posters, Past and Present, by M. Carter Roberts and Beatrice Short, published in the December number, is now available in reprint form, price 10 cents.

NURSE'S DAILY REPORT

Foreword: In the July, 1926, number of THE PUBLIC HEALTH NURSE we published instructions for the use of the new N.O.P.H.N. record forms then ready. We now publish a sample sheet of the Nurse's Daily Report and instructions for the use of these report sheets as drawn up by the N.O.P.H.N. Committee on Records.

The Nurse's Daily Report sheet is planned to give a picture of the nurse's day and also to serve as a basis for making up monthly and annual reports on staff activities.

It has been designed to permit of flexibility and so meet the needs of any type of agency. The items listed are recommended as those desirable for summaries in reports of nursing services. However, any items which are not applicable and do not seem necessary because of local conditions may be disregarded.

To make for uniform reporting the Committee offers the following recommendations:

1. That the following classifications be made of staff activities:

Visits
Conferences
School
Educational
Organization
Office
Travel
Other

2. That visits for Nursing Service be classified as follows:

Maternity
  Ante Partum
  Delivery
  Post Partum
  New Born
Health Supervision
  Infant
  Preschool
  School
  Adult
Morbidity
  Non-communicable
    Acute
    Chronic
  Communicable
    Tuberculosis
      Post Sanitarium as a sub-group
    Venereal
    Others
Not Found, Not Home, Not Taken Up
In Behalf Of

These divisions are in general the same as those recommended by the Report of the Committee to Study Visiting Nursing with certain changes in grouping and terminology.

3. That the technical term case—an instance of disease or the non-disease condition of maternity—be broadened to include individuals under health supervision.

New case is one for which a new record is being made.

In Health Supervision, in addition a new case is one in which an individual under care passes from one age group to another age group as from Infant to Preschool. It is dismissed in the Infant group and is a new case in the Preschool group.

If a case has been dismissed under Morbidity Service and the individual nursed comes again under care in relation to a different diagnosis irrespective of the time which has elapsed since the case was dismissed, it is a new case.

A second attack of an acute disease, as pneumonia, is a new case.

A new pregnancy in the same individual is a new case.

Re-admitted case is one which has been previously dismissed and comes again under care, and which at re-opening is not a new case as above defined.

4. That terms used on report form have the following meaning, terms not used uniformly only, being defined.

Age Group
  Infant: Under 1 year
  Preschool: 1 year of age and under 6, if not in school
  School: 6 years of age and under 14 and others in school
  Adult: all 14 years of age and over, if not in school

Field visits "refers to and may include any, or all, of the types of service which a nurse may perform in behalf of a patient outside the clinic or her office, such as: (1) Observation and investigation; (2) Visits

NURSE'S DAILY REPORT

NURSE Mabel Jones DISTRICT I DATE Feb. 16th 1927

NAME AND ADDRESS		TIME	CASE (New, Readmitted, Current, Dismissed)	AGE GROUP (Infant, Pre-School, School, Adult)	FIELD VISITS: MATERNITY (AP, Del., PP, NB)	FIELD VISITS: HEALTH SUPERVISION (Infant, Pre-School, School, Adult)	FIELD VISITS: MORBIDITY NON-COMM. (Acute, Chronic)	FIELD VISITS: MORBIDITY COMM. (TB, PS-TB, VD, Other)	Not Found, Not Home, Not Taken Up	In Behalf Of	Fee
Office		9:00–9:15									
Rogers, Mollie	4 Greene Street	9:25–9:50	C	A			Ac				$1.00
Wilson, Bridget	12 Jay Street		C	A	PP						1.00
Wilson, Baby		10:00–10:55	C	I	NB						.25
Ross, James	9 Pearl Street	11:10–11:30	C	A						✓	
Logan, Mary	6 East 8th Street	11:40–12:15	N	S				TB			Free
Lunch		12:15–1:15									
Office		1:30–2:00									
Office		4:00–4:15									
Reed, Edna	9 Walker Street	4:25–5:00	RE	PS		PS					Free
TOTAL			6	6	2	1	1	1		1	5

CONFERENCES: MEDICAL OR NURSING	ATTENDANCE	TIME
Preschool : medical	15	2:00–4:00

N 1	I 1	AP	I	AC 1	TB* 1	BF			3 Full
RE 1	PS 1	DEL	PS 1	CH	(PSTB)	BN			2 Free
C 4	S 1	PP 1	S		VD	NT			
D	A 3	NB 1	A		O				

EDUCATIONAL ACTIVITIES

Classes and Clubs

Community

Staff

ORGANIZATION ACTIVITIES

OFFICE ACTIVITIES

Office Visits

Records

Conference with Supervisor

Tel. Consultations

OTHER ACTIVITIES

TIME SUMMARY

	Hrs.	Min.
Visits	3	
Conference	2	
School		
Edu. Act.		
Org. Act.		
Office		50
Travel	1	10
Other		

Total Hrs. on Duty 7

From 9 AM to 5 PM

Total Visits 6

*Include Post Sanatorium

HEAD & WHEELER CO., CHICAGO NOPHN 64

of instruction and demonstration; (3) Visits where bedside nursing is performed; and (4) Visits of a social service nature which are necessary in behalf of a case." *

The only visits to be counted are those for which an entry has been made on a record or special report, as on report for health or other agencies.

All visits are counted according to the number of individuals served. Example: A single visit to a home is to be counted as one visit if service is rendered to only one individual, or as two or three visits if service is rendered to two or three individuals for whom separate entries are made on records or special reports.

* Appraisal Forms for City and Rural Health Work. American Public Health Association.

All visits are to be classified according to the type of nursing service given, as shown by type of nursing record used.

New Born as reported under the heading Maternity Service refers to infants under one month to whom care is given in connection with post-partum care of mother. If visit is primarily for health supervision of child, visit should be classified as Infant Health Supervision without special separation as New Born.

Morbidity service is care of sick person under or pending medical supervision.

Acute combines acute medical and acute surgical conditions under one heading, rather than having separate headings as recommended by the Committee to Study Visiting Nursing.

Communicable refers to cases of disease listed as such by local boards of health.

Visits to contacts of communicable disease cases and to individuals suspected of having a communicable disease are to be listed under the service for that disease.

Example: Helen Smith is a preschool child carried for Health Supervision. John Smith, her brother, develops diphtheria and Helen is visited for inspection and instruction.

This visit is entered as Other under the heading of Morbidity: Communicable, and not under the heading of Health Supervision.

Post sanitarium tuberculosis cases refers to tuberculosis cases which have had at least three consecutive months' treatment and education in a sanitarium at any time.

Not taken up refers to visits to individuals who have been referred for nursing service, which show no necessity for nursing care and for which no nursing record is opened.

Conference, often miscalled "clinic," is a meeting arranged for at a definite time and place for examination or inspection and individual discussion of health problems.

Attendance at a conference is the number of individuals served and for whom entries are made on the individual record.

Classes and clubs are meetings arranged for at a definite time for the purpose of continuous group instruction.

Educational activities include meetings addressed or attended by staff for educational purposes, also preparation of educational publicity, exhibits, etc.

Organization activities include visits made and meetings attended in relation to organization work.

Under OFFICE ACTIVITIES the only office visits and telephone consultations to be recorded are as follows:

Office Visits: Only such visits of individuals to office, at which time a definite health service is rendered to the individual and entry made on record or special report.

Telephone Consultation: Only such telephone calls to or regarding individuals under care or referred for care and for which an entry is made on a record or special report.

SUGGESTIONS FOR THE USE OF THE FORM

If information on time distribution is desired, the time spent in a visit or meeting may be entered in column headed TIME; either as (a) Total time spent: 20 min., or (b) time entering and time leaving: 10:00–10:20.

In making entries in columns the abbreviations as given at the foot of the columns may be used.

Example: A second visit is made from 10:15 to 10:40 on Tom Jones, 40 Green Street. Tom is 7 years old, has tonsillitis and full pay is collected for the visit.

				Morbidity	
Name and Address	Time	Case	Age Group	Non Comm	Fee
Tom Jones, 40 Green St.....	10:15–10:40	C	P S	Ac	$1.00

The sum of all entries in each column should be put in line marked "Total." If desired, detailed distribution of the total number by sub-classification in each column may be entered at bottom of column.

Under TIME SUMMARY may be entered the total time spent in the activities designated.

School time is time spent in school nursing within the school building. Any entry for time spent in school nursing presupposes the use of a separate school nursing report.*

Office time includes all time spent in the office regardless of activity not covered in other entries.

The forms are available from Meade and Wheeler Co., 1022 South Wabash Avenue, Chicago, Ill.

* School report form in preparation.

FINANCIAL STATEMENT FOR 1926

Experience has taught us that our members are interested in knowing each year what money was received by the Organization and how it was spent, but do not want to wade through the intricacies of an auditor's report of assets and liabilities to get this information. For that reason we are giving in this statement only the figures that represent income and expenditure for 1926. We shall be glad to supply any supplementary information on this statement or the budget for 1927 upon request.

In 1926 our income from corporate membership was larger by some $7,000 than in 1925 due to the acceptance, by 95 of our member agencies, of the percentage plan for increased dues. This almost makes up for the decrease in contributions over that same period, which is of course the purpose of the plan. The decrease in contributions was expected as the grants from the Foundations have come to a close and several of our large contributors are cutting down on their gifts, feeling that the groups whom the N.O.P.H.N. serves should begin now to assume a larger responsibility for the support of their National Organization. Membership dues support our National Headquarters and its general administrative procedures while contributions make possible the various services of the Organization.

Included in the item for administration is the sum set aside each month for the sinking fund to retire our $7,000 debt. This procedure was voted by the Board last year and already $4,000 has been paid off, leaving a balance of $3,000, which we hope to clear up entirely this year, enabling us to start 1928 free of all such indebtedness.

To all our members will be sent a brief annual report describing the activities and special accomplishments of the Organization during 1926 and showing the apportionment of income to the different projects. Anyone wishing a copy may have one upon application

FINANCIAL STATEMENT FOR 1926

Abstracted from Auditor's Report

INCOME

MEMBERSHIP DUES		
Individual	$12,694.65	
Corporate	10,710.77	
CONTRIBUTIONS	40,962.36	
MAGAZINE	12,775.44	
MISCELLANEOUS EARNINGS	3,959.38	
SPECIAL FUNDS		
American Child Health Association	10,554.48	
Financial Study	5,000.00	
		$96,657.08

EXPENSE

Administration	$10,320.92	
Accounting Service	2,610.00	
Affiliated Memberships	1,055.00	
Educational Propaganda	213.97	
Travel, representation at meetings	112.44	
Convention	1,535.56	
Insurance	29.93	
Licenses	25.00	
Grading of Schools of Nursing	2,500.00	
Vocational Placement discount	52.55	
Advisory Service (includes Library Service and a part of Nursing Service, A.C.H.A.)	11,714.79	
Magazine	24,584.41	
Membership	5,014.89	
Promotion of Child Health Nursing	10,554.48	
Statistical	4,614.04	
Vocational	9,464.83	
Financial Study Fund	6,881.36	
		$91,284.17

TWO TRUE TALES

One of the nurses of the Boston Community Health Association was making a visit to an expectant mother, a friendly but not too Americanized Greek woman. With the usual interest in the past health of the patient, the nurse asked, "Mrs. Orvades, have you ever had a miscarriage?"

Mrs. Orvades gave an expressive shrug and said a little apologetically,

"I don't know. I've had a lot of nurses, but I don't know any of their names."

One of the nurses of the Philadelphia Visiting Nurse Society sat down in a trolley car one day opposite a mother and two little children. One of the children, evidently finding the lady in the uniform familiar, said, "Nurse, have you a baby in your bag?"

"Hush," said the older child with an air of sophistication, "Don't ask her for it. Some other lady has ordered it."

RED CROSS PUBLIC HEALTH NURSING

EDITED BY ELIZABETH G. FOX

CHAPTER VISITING

Public health nursing under the Red Cross receives four important benefits: the stimulation and inspiration of belonging to a world-wide organization devoted to a lofty ideal, standards, personnel, and consultation service.

The Red Cross has organized the latter, consultation service, in two parts: *one,* through correspondence between the Chapters and the administrative staff and Service heads in the National and Branch offices; and *two,* through the visits of the field staff to the Chapters.

Chapter visiting is especially valuable and important because advice can be based on a more comprehensive and intimate understanding of the situation gained through seeing the Chapter in operation, studying its problems on the ground in their own setting, viewing all sides of these problems and talking with all concerned.

Chapter visits are constructive, destructive or without influence one way or the other. Obviously constructive results are our aim, but no field representative is superhuman enough to hit the bull's eye every time. This outline is designed to help our nursing field representatives on whom we depend so mightily to have a high record of hits.

These paragraphs are the introduction to an outline, *Chapter Visiting,* recently prepared by the Public Health Nursing Service for the guidance of the twenty-five or more Red Cross nursing field representatives. The outline deals with the objectives and plan of a Chapter visit, points to be remembered in successful supervision, organization matters to be reviewed and technical assistance to be given. In its final form the outline contains many modifications offered by the nursing field representatives themselves in the course of group discussion of the original draft.

From the twenty-three pages of mimeographed text we select the objectives of a Chapter visit and certain of the points on successful supervision as of most interest to our readers.

The objectives of a Chapter visit by a nursing field representative are defined as follows:

I. To stimulate and inspire both Chapter and nurse to an appreciation of their opportunities, responsibilities and achievements.

II. To help and encourage Chapter and nurse to lay firm foundations particularly with reference to the following points:

If Chapter Service
An active, strong and representative Nursing Activities Committee.

If Joint Service
An active and strong Joint Committee fairly representing the participating agencies and recognizing Red Cross standards and policies.

Clear understanding on part of Committee and nurse of their respective responsibilities.

Regular and profitable committee meetings.

Annual budget—including estimated expenditures, expected income and plan for raising additional revenue where needed.

Sound program looking well toward future.

Definite policies in accord with national policies.

Definite plan of work.

Proper articulation of public health nursing service with Chapter.
Nursing Activities Committee and Executive Committee,
Nurse and other Chapter workers,
Nursing program and Chapter program.

Satisfactory relations with health authorities.

Satisfactory relations with school authorities.

Satisfactory relations with Medical Society.

Careful technique.

Scrupulous observation of ethics.

Articulation of nursing service with other health and social agencies.
Business-like handling of reports, records, funds.
Adequate equipment.
Adequate publicity.
Good working and living conditions for nurse.

III. To give the National or Branch Office a true and adequate picture of the public health nursing situation and its bearing on the Chapter.

Obviously it is not intended that all of this ground shall be covered in a single visit.

Among the points in successful supervision are these:

Visits are made not to check up and criticise, but to help Chapter and nurse to see problems more clearly and *to think their own way through to a solution.*

Let them talk first. Don't start making suggestions until you have a clear understanding of situation. As far as possible get them to make their own suggestions.

To take firm root plans and policies must be the outcome of their own deliberate conviction. Action taken hastily as a result of nursing field representative's stimulation without clear understanding and real desire oftentimes turns out to be only a flash in the pan—which often means: plant an idea on one visit and then wait until the next visit until it has had time to germinate to discuss action.

Putting nurse or committee on the defensive usually closes their minds to suggestion.

Don't take them too seriously or encourage them to take themselves too seriously. Seeing the funny side of a situation often clears the air when overcharged. Knowing that their difficulties and struggles are more or less universal and not insuperable also helps.

Be simple and definite. Don't take ready understanding for granted.

Don't leave nurse or committee in a state of discouragement. Doubtless they have made mistakes—everybody does—but they have also made good on some, perhaps many, points. Mistakes must be considered but they should not overshadow the good work. Even if they have failed badly leave them at least one leg to stand on and encourage them to believe they can succeed.

Give the nurse every opportunity to take the lead; don't stand in her light.

Encourage by giving Chapter and nurse credit for their contribution to public health nursing.

In a controversy—
Withhold judgment until you have heard both sides.
Keep the discussion on the principle involved and not on personalities.
Conciliate—don't fan the flame by taking sides.
Bring the contending groups together (after the way is prepared) to be sure you all understand each other.

Keep your own sense of humor.

The American Association for Medical Progress points out that the Health Section of the League of Nations in a recent report states that smallpox "is becoming increasingly rare on the continent of Europe." The majority of cases in Europe, it states, are found in England. The Association contrasts this with the fact that in the United States more than 27,000 cases of smallpox were reported during the first ten months of 1926 and that the United States still occupies an unenviable position, compared with European countries, so far as smallpox prevalence is concerned.

POLICIES AND PROBLEMS OF PUBLIC HEALTH NURSING SERVICES

The full list of questions now being taken up in this department was printed in the January number.

Question 3. How far out of town should a visiting nurse association send its nurses to do insurance or other contract work?

I am of the opinion that no visiting nurse association should offer a service to insurance companies or do other contract work in localities where such service cannot be available to the community as a whole. Therefore, it seems necessary to think in terms of cost per visit in transportation plus bedside care, and what a community can be asked to pay. Should great distances or difficult transportation make the cost of the visit prohibitive, it would not seem constructive to build such a service to be subsidized in some other way, unless it is temporary for the purpose of research or demonstration.—*Visiting Nurse Association, St. Louis, Missouri.*

This must depend on

The budget of the association.

The ability of communities outside the city limits to develop their own nursing service.

Transportation facilities.

The ability of the association to fulfill obligations already undertaken within their own limits.

In one city at least it has been found much more effective to take the city limits as a hard and fast boundary for accepting cases. The result has been that outlying communities have developed their own service. Such a policy probably would not apply to a smaller community where the people living directly outside of the given community are isolated families not necessarily forming communities of their own. I see no answer to that question except a pragmatic one—how much can be done with the given staff at not too great expense because of distance.—*Visiting Nurse Society, Philadelphia, Pa.*

Contract service should not be considered apart from the general service of a visiting nurse association. Industrial contracts are merely an assurance to the association that a percentage of the work undertaken will produce an income.

The Detroit Association is serving a large metropolitan area, 14 towns and villages outside the city limits. The extension of service has always been based on the general need of the community, its accessibility, and the Association's financial budget.

It is difficult to say how far out of town a visiting nurse should go. It is a question of administration of work which may be poorly or well done. If the Association follows the branch station plan, and considers the home location of its nurses in making assignments and provides the nurses in outlying territory with automobile service, there seems no reason why nursing service cannot extend twenty miles out of town.

In this connection I would like to have a discussion on: "What are the advantages and disadvantages of our large city visiting nurse associations controlling the nursing service in the suburban towns?"—*Visiting Nurse Association, Detroit, Michigan.*

When I came to this Association 3½ years ago the nurses were covering three outside towns all reached very easily by street car and bus although two of the towns are on the opposite side of the river and in a different county. The work was started primarily to do the work of the Metropolitan Life Insurance Company but later pay and free cases were taken. None of the towns had any representation on the Board of the Association and no

special effort was made to interest the community in the service. I have urged, and the Board has considered at several times, inviting representative people from these towns to become Board members. It is now being reconsidered and within a short time we hope to have representatives of the towns on the Board. It is my own feeling that before any Association should undertake work in outside towns for insurance companies—

A study of the community and its needs should be made and if the work is started it should not be simply for insurance companies but should cover free and pay cases.

That there should be a representative on the board and that gradually the town should be made to assume financial responsibility even if supervision is given from the older association.

Eventually the town should have an independent service.—*Visiting Nurse Association, Newark, New Jersey.*

We have a definite understanding with the Metropolitan Life Insurance Company that we confine our work to the city limits, the only exception being in the case of group insurance where the policy holders live within a reasonable distance of the plant. We do not extend care to individual policy holders outside the city limits.—*Public Health Nursing Association, Oklahoma City, Oklahoma.*

A visiting nurse association should not accept contract work to make visits outside the average density of population unless the contract makes provision for the higher cost of such visits. A contract on the fee basis, not limited to certain districts or providing for regulation of fees because of distances, obligates the association to make visits to outlying districts for the same fee for which other visits are made, and the visiting nurse association must bear the difference in expense.

It seems to me that the real issue is not the distance nurses are sent, but whether the contract company is really willing to pay for such nursing service when it involves practically trebling the cost of an average visit, and if not, whether the visiting nurse association can or is willing to bear this cost for altruistic and educational reasons.—*Staten Island Branch, Henry Street Visiting Nurse Service, New York City.*

Our Community Chest area is fifty-two square miles, therefore we serve all that come within that territory. Outside this area makes a higher cost per visit. We have been asked to take on additional territory by various interested parties, but our Board and the Community Chest directors feel that it would not be fair to use the Chest funds for territory out of the Chest area, unless that locality would pay for an automobile, its upkeep, nurse's salary and their proportion of overhead expense. There are so many unsupervised pieces of work being done in the rural sections that large organizations ought to be financially reimbursed for such supervision provided. The nurse in that locality could then have the advantage of staff contacts.—*Nursing and Public Health Association, Springfield, Mass.*

The Public Health Nursing Association is supported by the Community Chest of Louisville and Jefferson County. Many large subscriptions to the Chest are made by people who live outside the city limits, yet the size of our nursing staff does not permit us to offer visiting service to the people of the county. The city limits have been taken as a boundary line and we do not take cases outside of this limit. This applies to all sources from which we receive calls; that is, insurance companies, contract work for industrial companies and from the public at large. Unless a definite boundary is decided upon the Association is constantly faced with the necessity of deciding which cases can or can not be taken—which is an embarrassing procedure.—*Public Health Nursing Association, Louisville, Kentucky.*

If the surrounding towns would share in the expenses we could without a doubt enlarge our insurance and contract work. Our contract with the insurance company is strictly within town limits but we often receive calls from outside, usually through some misunderstanding on the part of the agent. We feel it necessary to keep within our territory. If we step outside of the city limits for one patient we would be swamped with calls from nearby neighbors.—*Newburyport Health Center, Newburyport, Massachusetts.*

Question 4. What is the policy for limiting calls within the city limits but inaccessible from street cars and other means of transportation?

Our Association at present is not limiting its service within the city boundaries. However, there has been a policy limiting the distance which the nurse was required to walk to six city blocks beyond the street car lines.—*Visiting Nurse Association, St. Louis, Missouri.*

If an association has accepted the responsibility for covering the visiting nursing service within a given area, it seems to me it is its responsibility to make it possible to respond to all calls. This undoubtedly would mean adding one or more automobiles as part of the association's equipment.—*Visiting Nurse Society, Philadelphia, Pa.*

I can see no excuse for limiting service within the city because of lack of city transportation facilities, in this age of automobile travel.—*Visiting Nurse Association, Detroit, Michigan.*

We have not limited calls because of inaccessibility. The city has good trolley and bus service and while we do not own any cars two nurses who own cars are given mileage for their use in the field and cover districts far distant from our center. Last winter a group of women organized a volunteer motor corps which has been very helpful. We have one or two cars five mornings a week. We try to let each car take two or three and sometimes four nurses into their districts. Then the nurses arrange who will keep the car to take them from case to case. (During the summer the volunteers were away but they came back to us this fall and were most welcome.)—*Visiting Nurse Association, Newark, New Jersey.*

All of our staff have cars so there are no patients inaccessible.—*Public Health Nursing Association, Oklahoma City, Oklahoma.*

Staten Island has fifty-nine square miles, with a population of 130,000 scattered over it. Except in two districts, it is more economical to use automobiles than to use trolleys. We accept all calls.

Much of our territory is inaccessible to street cars and distances are too great to make walking practicable. Therefore, automobiles are a necessity.—*Staten Island Branch, Henry Street Visiting Nurse Service, New York City.*

No case is inaccessible if a home in that spot has been established; but the question would probably be, can an organization afford to spend hours in travel to give care to one case? We have four Fords mainly used for rural work. In one section the nurse travels three-quarters of an hour in the Ford, then walks half an hour to reach her case. Our policy is to care for the isolated type of case in preference to a city case. The need as a rule is greater.—*Nursing and Public Health Association, Springfield, Mass.*

The question of limiting calls because of geographical inaccessibility has never been considered by the Providence District Nursing Association. Service is offered, and has always been furnished to the entire city, irrespective of location.—*District Nursing Association, Providence, R. I.*

No definite policy has been worked out in regard to limiting calls within the city limits but inaccessible to street cars and other means of transportation. At least one-third of our nurses have their own cars which makes transportation a much simpler matter.—*Public Health Nursing Association, Louisville, Kentucky.*

In a great many places where an automobile is available for district nursing service, it would, I believe, be possible to cover a considerably larger area than we do. Our territory covers a space about four miles in length and two miles in width. We have the use of a taxicab for transportation, and also use a trolley car whenever possible to cut down expense.

The question of time and expense would make it impossible to take calls out of our territory.—*Newburyport Health Center, Newburyport, Massachusetts.*

REVIEWS AND BOOK NOTES

VENTILATION AND HEALTH

By Dr. Thomas D. Wood and E. M. Hendriksen

D. Appleton and Company, New York. Price $2.00

Points on ventilation which a public health nurse will frequently be making in her educational work are listed as follows in this interesting book:

The first requisite of fresh air is moderate temperature. Of second importance is gentle motion without draft and a moderate humidity, while a slight variability in all these elements is desirable. The condition resulting from the proper observation of these rules is one closely resembling the outdoor air on a pleasant summer day and is the goal at which all indoor ventilation should aim.

Results of bad ventilation are also given. When the body is overwarm and perspiring the effect is brain anaemia and a lowering of the tone and nutrition of the stomach, lungs, heart and other internal organs. Continual living in an overwarm atmosphere results in a loss of appetite and in treating children for digestive disorders it is well to keep this in mind.

The public health nurse, the author says, in providing ventilation for her patients, should teach them to experiment in their rooms in order to secure the above-mentioned condition, and he gives in an interesting fashion ways in which it may be arrived at in various types of dwelling places.

THE CONQUEST OF DISEASE

By Thurman B. Rice, A.M., M.D.

The Macmillan Company, New York, 1927. Price, $4.50.

The eventual conquest of the communicable diseases depends upon the inteiligent co-operation of the sanitarian and the general public. Both need guidance and for this purpose there are now available innumerable books, of which a few are worth reading. Dr. Rice's book is in this last category. He has written without employing the usual disquieting technicalities and yet has avoided treating his audience like morons. His book is intended primarily for the lay reader, though it may also have some value for the student. The first part discusses rather concisely such general topics as the historical development of the control of the transmissible diseases, and their causes and dissemination; the second takes up in detail various specific infections, such as the intestinal diseases, those which are saliva borne, the ones carried by insects, and various contact infections; the third presents succinctly the means by which transmissible diseases in general are controlled. There are numerous useful diagrams and not once has the author offended his readers with those horrible circle charts adored by some writers. A good index is included. The book is scientifically sound, neither too conservative nor ultra radical, and it is guiltless of fads. While a trifle sketchy in parts, it is the type of book which public health nurses can recommend with impunity to those of their clients who need references to useful public health literature, and might be read with profit by themselves.

JAMES A. TOBEY

A VADE MECUM FOR NURSES AND SOCIAL WORKERS

By Edward F. Garesché, S.J.

The Bruce Publishing Company, Milwaukee, Wis., 1926. Price, $1.00.

A revised edition of this admirable little book has recently been issued. It reflects, and helps others to reflect, the serenity in St. Teresa's book-mark quoted in the volume:

Let nothing disturb thee,
Nothing affright thee,
All things are passing,
God never changeth,
Patient endurance
Attaineth to all things;
Who God possesseth
In nothing is wanting;
Alone, God sufficeth.

The Children's Bureau has just issued the following important pamphlet publications:

The Physician's Part in a Practical State Program of Prenatal Care, by Fred L. Adair, M.D., which also contains Standards of Prenatal Care by Robert L. DeNormandie, M.D.

How to Make a Study of Maternal Mortality, by Robert L. DeNormandie, M.D.

All nurses interested in maternity and child welfare will find these pamphlets invaluable. Government Printing Office, Washington, D. C. Price 5 cents each.

We have just received from the League of Red Cross Societies their impressive 1927 Calendar. It ranges in alphabetical order from Albania to Venezuela. X, Y, and Z have apparently not yet been reached by the League. Each page describes some special Red Cross activity in the individual country. It is liberally illustrated, and makes a fascinating lesson in geography. We hope to be well informed about all the lesser known countries by the end of the year.

The report of the *Child Health Demonstration of Mansfield and Richland County, Ohio,* 1922 *to* 1925, is now available in printed form. The Demonstration, which it will be recalled was a pioneer effort in demonstrations of methods of improving health conditions of child life, was financed by the American Red Cross and supervised by a Committee representing that organization, the American Child Health Association, the National Tuberculosis Association, the National Organization for Public Health Nursing, and the National Child Labor Committee. The report presents the result of this four years' work in developing a child health program in a typical American community. There is an immense amount of valuable and most suggestive information on almost everything relating to a community health program packed into this volume. The part public health nurses play is evidenced on almost every page, also the close interrelation of their work with that of the other specialists. There are many illuminating tables. Chapter 5 gives the results of a study of the cost of nursing work in the city of Mansfield in the year 1924. The chapters on nutrition teaching and nutrition activities are of special interest. A food habits score and a suggested budget for a family of five on a moderate income add greatly to the interest of this phase of the work. We recommend a careful perusal of this volume. It provides valuable new information as to how measures for childhood protection can be best incorporated into a general program and also discloses certain pitfalls.

The report can be obtained from the American Child Health Association, 370 Seventh Avenue, New York. Price $1.00.

Volume IV of the American Health Congress Series contains the reports of the joint session of the American Social Hygiene Association and the National Committee for the Prevention of Blindness on *Relation of Venereal Diseases to Vision Impairment* and of the American Social Hygiene Association and the American Public Health Association on *Venereal Disease Control.* In his paper on Venereal Disease Control from the Viewpoint of the National Voluntary Organizations, Dr. William F. Snow says:

> The nursing profession is coming to the front in dealing with this problem and is most urgently needed. . . . The nurse can reach the most precious part of all the population infected with these diseases—the mothers and children. . . . I have become very much of an optimist as to what the nurses are doing with the family group in relation to venereal diseases. . . . Nurses' organizations are doing a great deal. . . . Southern and western cities and states are trying out many interesting things. States like Tennessee and Montana are adding trained nurses with social service experience to their staffs to study how far we can apply social service work to rural clinic facilities.

We recommend this valuable publication. It can be obtained from National Health Council, 370 Seventh Avenue, New York. Price 30 cents.

The Tennessee Public Health Nurses News Letter, published by the Division of Public Health Nursing of the Tennessee State Department of Health is the most recent addition to State Bulletins for nurses. No. 1 appeared in January and fittingly bears on the first page a lively illustration of a Birth Registration office. The narrative reports, news items, and suggestions make a most interesting number. One of the narratives gives an exciting account of a "Ford Adventure," the situation relieved we were glad to learn by a farmer and his mules. Our congratulations and good wishes for the new venture.

A series of articles on Teaching Health in College is appearing in the *American Journal of Public Health* in the January and February numbers. The third will appear in March.

The Family for February, 1927, contains a valuable piece of research in "Old Age Pensions" by Amelia Sears, with a bibliography.

Common — much too common — Colds, that distressingly universal malady, or particularly Why Do Children Have 'em? is discussed in the February number of *Children, The Magazine for Parents*. The gruesome subject is enlivened by some entertaining illustrations. The author, Russell L. Cecil, M.D., gives three factors as the reason why some do and some do not—heredity, temperament, physique—these beyond our control. He then discusses the practical factors which are: Exposure to Cold, Clothing, Poor Elimination, Ventilation, Tonsils and Adenoids, Infected Sinuses, and ends up with Prevention and Treatment. The fundamental principle is Rest. All simple and all pretty well known, but how rarely carried out fully and in intelligent sequence!

Dr. Cecil, by the way, is the author of *Colds*, one of the Appleton series of small books to which we have before alluded.

The Metropolitan Life Insurance Company issues a very practical pamphlet on the Common Cold. It seems worth while to attentively study preventive methods when we read a statement in *The International Medical Digest* for January, 1927, that it is conservative to assume that 75 per cent of all pneumonias are secondary to colds.

The Journal of the American Medical Association, January 29, 1927, contains an article by Frances Stern and Jean Reyner on The Use of Natural Foods in Treating Diabetic Patients of Foreign Birth, with a number of tables.

A small but excellent leaflet has been issued by the Bureau of Child Hygiene of the Maryland State Department of Health, *Mid-Winter Care of Your Baby*. Summing up the suggestions for keeping the baby or young child well during the winter.

Feed him properly so as to avoid rickets; and to build up his resistance to disease.

Keep the house well ventilated and take the baby out in the fresh air and sunlight as the weather permits. Give him a midday nap.

Dress him according to the temperature.

Give him a cool sponge and a vigorous rubdown every morning.

Keep him away from every one who has a cold or other respiratory infection.

A Five-Year Program for the Committee on the Grading of Nursing Schools, Plan and Budget submitted by Dr. May Ayres Burgess and adopted by the Committee, November 18, 1926, is now printed in pamphlet form, price 25 cents. Committee on Grading of Nursing Schools, 370 Seventh Avenue, New York.

NEWS NOTES

The Annual Meeting of the Federation of Women's Boards of Foreign Missions of North America and the North American Missionary Conference was in Atlantic City in January. Miss Cora Simpson of China delivered the opening address on the subject "That They Might Have Life," speaking of the work of the missionary nurses in all lands and especially in China and of the place nurses have made for themselves in that land. Other topics of interest to nurses on which the conference heard various viewpoints were public health, international peace, industry and education.

At the Annual Meeting of the New England Industrial Nurses Association on January 8, Miss Melda F. MacDonald of Salem, Massachusetts, was elected president for 1927. Dr. Leroy Miner, Dean of the Harvard Dental School, was the speaker of the evening and gave an interesting address on the Medical Aspect of Dentistry.

The 1927 Convention of the National League of Nursing Education will meet in San Francisco, California, June 6–10, inclusive (not in Oakland, as announced in the December *Journal of Nursing*). Convention headquarters will be in the Cliff Hotel. The rates (European plan) have been adjusted on a reasonable basis: room for one person, $3.50, $4.00, $5.00; room occupied by two persons, $6.00, $7.00, $8.00. Requests for reservations should be addressed to the hotel manager.

Excursion rates will presumably be the same as in 1926: that is, $142.62 for round trip ticket between New York City and San Francisco, going and returning by direct route; one way by Portland or North Pacific coast, $18 more. No arrangement will be made this year for tickets on the certificate plan, to obtain the benefit of which 250 individuals must present a certificate. The program will be published in the April *Journal*.

The 1927 California State Nurses Convention is to be held in Oakland during May. Miss A. Sellander is chairman of arrangements, Miss M. Aitken of program arrangements and Miss Catherine S. Bastin is also a member of this committee; Miss Mabel Rainbow is chairman of arrangements for Public Health Nursing and Miss Florence Bussell is chairman of program arrangements for Public Health Nursing. Suggestions of all kinds will be welcomed by the committees.

The fifty-fourth annual meeting of the National Conference of Social Work will be held at Des Moines, Iowa, May 11-18, 1927. Approximately thirty kindred groups will hold annual meetings or conferences at the same time, with programs offering discussions of the particular interests and techniques now uppermost in social work. An advance program with full information may be had from the General Secretary, National Conference of Social Work, 277 East Long Street, Columbus, Ohio.

The Middle Atlantic Division of the American Nurses Association will hold its biennial meeting in New York City, April 28 and 29, 1927. All nurses in the six states representing the Middle Atlantic Division are urged to attend. The program for the meeting will be printed in our April number.

The Fourth Annual Meeting of the American Child Health Association will be held in Washington, D. C., May 9–11.

The Northwestern Conference on Child Health and Parent Education will meet for a three-day session in Minneapolis, March 8–10.

Educational Booklets that *delight children*

WITH charming text and quaint pictures printed in colors, these two booklets tell the story of the growth of wheat and its use as a food. They have met with an enthusiastic reception among educators because of their immediate attractiveness to children and the soundness of the nature and health teaching they convey.

"Hidden Treasure" is written to appeal to children in the second and third grades. "The Wonderful Lunch Boxes" is designed for fourth, fifth and sixth grade pupils. Both make splendid supplementary reading material for the class room, and are also suggestive of school or home projects.

We should be very glad to send you, on request, as many of each of these booklets as you desire—either for distribution among grade teachers or for use in your own health center classes. You will find it desirable to have an individual copy for each child. Just fill out the coupon, and the booklets will be sent promptly, without charge.

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2-3-27

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Please send me, free, the following booklets:
..... copies "Hidden Treasure"
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The Isabel Hampton Robb Memorial Fund Committee is offering seven scholarships of $250 each for successful applicants for courses in teaching or administrative work during the winter of 1927–28.

Until May 1st the lists will be open to nurses engaged in any branch of the profession who fulfill the following requirements:

Membership in the American Nurses' Association.

One year of executive or teaching experience.

Eligibility to enter the institution chosen for the desired course of study.

The scholarships are competitive and will be awarded to the seven who stand highest among all who apply. For application blanks write to the Secretary, Katharine DeWitt, 19 West Main Street, Rochester, N. Y.

The United States Civil Service Commission states that a number of hospitals of the Veterans' Bureau are sorely in need of occupational therapists.

APPOINTMENTS

Miss Edith Countryman has been appointed to the State Department of Health of Iowa in the capacity of organizer of a state division of public health nursing. The department undertaking this work has asked the legislature to make permanent provision for both a Division of Public Health Nursing and a Division of Nursing Education. Miss Countryman has been loaned to the department by the State Tuberculosis Association until such time as permanent arrangements may be made for carrying the work on by the legislature.

Miss Mabel E. Uzzell, who has been directing the Committee on Health and Social Welfare of the American Red Cross in its seven-year demonstration in Wayne County, Michigan, is now bringing her program to a close. The field nurses of the Red Cross staff are being taken over by the office of the County School Commissioner and all but one or two of the large population districts of the county now have their own nursing service covering their outlying rural sections. Miss Lois Barrington Sharpe, Supervising Nurse of Wayne County, has been appointed regional rural advisor for the study.

NOTES FROM THE STATES

Connecticut

At the annual meeting of the Graduate Nurses' Association of Connecticut held in Waterbury in January the following officers were elected:

President, Margaret Barrett, R.N.; First Vice-President, Abbie M. Gilbert, R.N.; Secretary, A. Lillian Forbush, R.N.; Chairman of the Public Health Nursing Section, Mabel Macdonnell, R.N.

Illinois

Dr. Robert B. Osgood of Boston will visit the Visiting Nurse Association of Chicago on April 8th as special lecturer for the celebration of the tenth anniversary of the beginning of aftercare work with children who have had infantile paralysis. This work, begun in November 1916 with one nurse, now requires eighteen nurses and the services of one other has been added for special work with children having cardiac trouble.

It is good news to learn that the Association was presented last month with a check for $500,000, the James Deering Bequest, the income of which will be used to open an eleventh substation, making twelve centers.

Another gift of $10,000 has been received by the Association which will be used for educational purposes.

Michigan

The Detroit District of the Michigan State Nurses Association held an open meeting February 4th. Miss Janet Geister spoke on "Shaping Nursing to Community Needs."

Virginia

The Graduate Nurses Association of Virginia will hold a conference in Norfolk, May 3-5. Miss Juanita Woods, chairman of the Public Health Section, will arrange a demonstration of the initiation of the student nurse in the public health field through a visiting nurse association, and Miss Katharine Tucker has been asked to speak on the value of such training to student nurses.